TEXAS REGISTER

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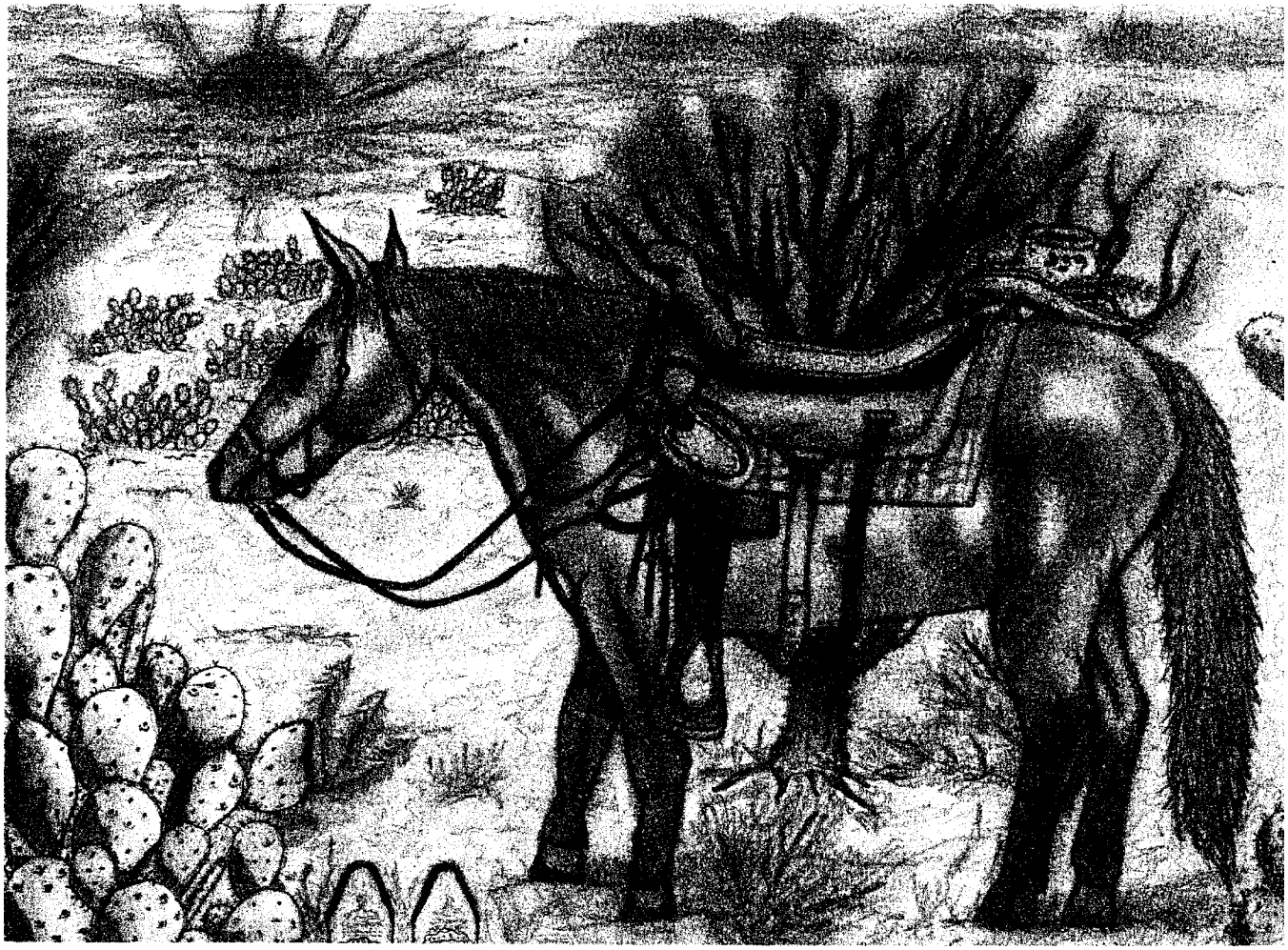

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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IN THIS ISSUE

Open Meetings

Statewide agencies and regional agencies that extend into four or more counties post meeting notices with the Secretary of State.

Meeting agendas are available on the *Texas Register*'s Internet site:
http://www.sos.state.tx.us/open/index.shtml

Members of the public also may view these notices during regular office hours from a computer terminal in the lobby of the James Earl Rudder Building, 1019 Brazos (corner of 11th Street and Brazos) Austin, Texas. To request a copy by telephone, please call 512-463-5561. Or request a copy by email: register@sos.state.tx.us

For items ***not*** available here, contact the agency directly. Items not found here:

- minutes of meetings
- agendas for local government bodies and regional agencies that extend into fewer than four counties
- legislative meetings not subject to the open meetings law

The Office of the Attorney General offers information about the open meetings law, including Frequently Asked Questions, the *Open Meetings Act Handbook*, and Open Meetings Opinions.
http://www.oag.state.tx.us/opinopen/opengovt.shtml

The Attorney General's Open Government Hotline is 512-478-OPEN (478-6736) or toll-free at (877) OPEN TEX (673-6839).

Additional information about state government may be found here:
http://www.state.tx.us/

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Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Opinions

Opinion No. GA-0690

The Honorable Bobby Lockhart

Bowie County Criminal District Attorney

Post Office Box 3030

Texarkana, Texas 75504

Re: Authority of City of Texarkana municipal officers under various circumstances (RQ-0717-GA)

S U M M A R Y

Article 2.124, subsection (b) of the Texas Code of Criminal Procedure grants limited powers to officers from an adjoining state while in Texas in circumstances where the municipal limits of a municipality are within one mile of the boundary between this state and the adjoining state. Under that provision, the jurisdiction of peace officers of the Texarkana, Arkansas Police Department extends to the municipal limits of Texarkana, Texas and not beyond.

Article 2.124(b) also grants those officers from the adjoining state the same powers, duties and immunities as an officer of this state who is acting in the discharge of an official duty. Thus, officers of the Texarkana, Arkansas Police Department, while in Texarkana, Texas, have the same authority to use deadly force as an officer of this state.

Under the Interlocal Cooperation Act, when peace officers of Texarkana, Arkansas are serving as law enforcement officers in Texarkana, Texas pursuant to the Interlocal Agreement, they are considered law enforcement officers of Texarkana, Texas. Thus, when serving pursuant to that agreement, they have the same jurisdictional limits and authority to use deadly force as officers of the Texarkana, Texas Police Department, except as limited by the Interlocal Cooperation Agreement.

Opinion No. GA-0691

The Honorable D. Matt Bingham

Smith County Criminal District Attorney

100 North Broadway, 4th Floor

Tyler, Texas 75702

Re: Whether a state judge is authorized to permit felony and misdemeanor probationers to travel temporarily outside the state or to reside outside the state (RQ-0723-GA)

S U M M A R Y

Through Code of Criminal Procedure article 42.12, the Legislature has authorized judges to determine the conditions of community supervision, including conditions about where the probationer may live and travel. This provision gives judges broad discretion to issue orders permitting probationers to travel or relocate outside the state.

Established common law provides that judges are not liable to civil actions for their judicial acts, and thus, it is likely that courts of other states would recognize the full scope of judicial immunity granted to Texas judges. However, this is a question for those courts to decide in the first instance.

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200900217
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: January 20, 2009

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PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 1. ADMINISTRATION

PART 8. TEXAS JUDICIAL COUNCIL

CHAPTER 174. INDIGENT DEFENSE POLICIES AND STANDARDS

SUBCHAPTER C. POLICY MONITORING REQUIREMENTS

The Task Force on Indigent Defense (Task Force) is a permanent Standing Committee of the Texas Judicial Council. The Task Force proposes new §§174.26 - 174.28, concerning policy monitoring requirements. The new sections are proposed to establish the guidelines for the administration of the Task Force's policy monitoring, which is designed to promote compliance by counties with the requirements of state law and Task Force policies and standards relating to indigent defense.

Glenna Rhea Bowman, Chief Financial Officer of the Office of Court Administration, has determined that for each year of the first five years the proposed new sections are in effect, enforcing or administering the sections will have no fiscal impact on state or local governments.

Ms. Bowman has determined that there will be no material economic costs to persons who are required to comply with the new sections, nor do the proposed new sections have any anticipated adverse effect on small or micro-businesses.

Jim Bethke, Director of the Task Force, has also determined that for each year of the first five years the rules are in effect the public benefit will be an improvement in the quality of indigent defense services because of corrective actions taken by local jurisdictions to more fully meet the requirements of state law related to the provision of indigent defense services.

Comments on the proposed new rules may be submitted in writing to Wesley Shackelford, Special Counsel, Task Force on Indigent Defense, P.O. Box 12066, Austin, Texas 78711-2066, or by fax to (512) 475-3450 no later than 30 days from the date that these proposed rules are published in the *Texas Register.*

DIVISION 1. DEFINITIONS

1 TAC §174.26

The new rule is proposed under the Texas Government Code §71.062, which directs the Task Force to distribute funds based on a county's policy compliance with standards developed by the task force and the county's demonstrated commitment to the requirements of state law relating to indigent defense. The section also directs the Task Force to monitor grants and enforce policy with grant terms. The rule is also proposed under §71.061(a), which requires the Task Force to monitor the effectiveness of the county's indigent defense policies, standards, and procedures and to ensure compliance by the county with the requirements of state law relating to indigent defense.

No other statutes, articles, or codes are affected by the proposed new rule.

§174.26. Subchapter Definitions.

The following words and terms when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Director. The director of the Task Force.

(2) Program Director. The local officer or employee designated under §173.301 of this title.

(3) Period of review. The 12 months preceding the date of the monitoring visit.

(4) Policies and Standards Committee. A committee of the Task Force charged with developing policies and standards related to improving indigent defense services.

(5) Policy Monitor. The employee of the Task Force who monitors the effectiveness of a county's indigent defense policies, standards, and procedures.

(6) Risk Assessment. A tool to rank each county's potential risk of not being in compliance with indigent defense laws.

(7) Task Force. Task Force means the Task Force on Indigent Defense.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900175
Wesley Shackelford
Special Counsel
Texas Judicial Council
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 936-6994

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DIVISION 2. POLICY MONITORING PROCESS AND BENCHMARKS

1 TAC §174.27, §174.28

The new rules are proposed under the Texas Government Code §71.062, which directs the Task Force to distribute funds based on a county's policy compliance with standards developed by

the task force and the county's demonstrated commitment to the requirements of state law relating to indigent defense. The sections also directs the Task Force to monitor grants and enforce policy with grant terms. The rules are also proposed under §71.061(a), which requires the Task Force to monitor the effectiveness of the county's indigent defense policies, standards, and procedures and to ensure compliance by the county with the requirements of state law relating to indigent defense.

No other statutes, articles, or codes are affected by the proposed new rules.

§174.27. Risk Assessment.

A risk assessment of each county shall be conducted by the policy monitor each fiscal year as the primary means of determining which counties will be selected for on-site policy monitoring. On-site monitoring visits to counties shall then be apportioned by administrative judicial region, county size, risk assessment scores, past visits and other documented factors. The risk assessment shall use a variety of factors related to the provision of indigent defense services, including but not limited to the following:

(1) Whether a county reported investigation and expert witness expenses;

(2) Whether a county reported reimbursements for attorney fees;

(3) Amount of per capita indigent defense expenses;

(4) Felony, misdemeanor, and juvenile attorney appointment rates;

(5) Population of a county;

(6) Whether complaints about a county have been received by the Task Force;

(7) Whether a county received an equalization award;

(8) Whether a county reported appeals cases; and

(9) Whether a county completed a voluntary self-assessment.

§174.28. On-Site Monitoring Process.

(a) Purpose. The process promotes local compliance with the requirements of the Fair Defense Act and Task Force rules and provides technical assistance to improve processes where needed.

(b) Monitoring Process. The policy monitor examines the local indigent defense plans and local procedures and processes to determine if the jurisdiction meets the statutory requirements and rules adopted by the Task Force. The policy monitor also attempts to randomly select samples of actual cases from the period of review by using a 15% confidence interval for a population at a 95% confidence level.

(c) Core Requirements. On-site policy monitoring focuses on the six core requirements of the Fair Defense Act and related rules. This rule establishes the process for evaluating policy compliance with a requirement and sets benchmarks for determining whether a county is in substantial policy compliance with the requirement.

(1) Prompt and Accurate Magistration.

(A) The policy monitor shall review the local indigent defense plans and determine if they require:

(i) Magistration within 48 hours of arrest;

(ii) That the right to counsel be communicated to the arrestee, the arrestee be provided an opportunity to request counsel, and both be recorded; and

(iii) Transmittal of the request for appointed counsel to the appointing authority within 24 hours of request.

(B) The policy monitor shall check for documentation indicating that the magistrate or county has:

(i) Informed and explained to an arrestee the rights listed in Article 15.17(a), Code of Criminal Procedure, including the right to counsel;

(ii) Maintained a process to magistrate arrestees within 48 hours of arrest;

(iii) Maintained a process for magistrates not authorized to appoint counsel to transmit requests for counsel to the appointing authority within 24 hours of the request; and

(iv) Maintained magistrate processing records required by Article 15.17(a), (e), and (f), Code of Criminal Procedure, and records documenting the time of arrest, time of magistration, whether the person requested counsel, and time for transferring requests for counsel to the appointing authority.

(2) Indigence Determination. The policy monitor shall review the local indigent defense plans and determine if they:

(A) Specify procedures and standards for determining whether a defendant is indigent;

(B) Apply the procedures and standards to each defendant in the county equally, regardless of whether the defendant is in custody or has been released on bail; and

(C) In the case of juveniles, specify that the income and assets of the parent or other person responsible for the juvenile shall be considered in determining the indigence of the child.

(3) Minimum Attorney Qualifications. The policy monitor shall review the local indigent defense plans and documentation to determine if they:

(A) Specify objective qualifications that attorneys must meet to be eligible for appointment, including the continuing legal education (CLE) requirements set out in §§174.1 - 174.4 of this title and annually track attorney CLE hours;

(B) Require each attorney applying to be on an appointment list be approved by a majority of the judges who try criminal cases at that felony or misdemeanor offense level, respectively, or by a majority vote of the juvenile board in juvenile cases; and

(C) In the case of juveniles, recognize the differences in qualifications and experience necessary for appointments for different offense levels as required by Texas Family Code §51.102(b)(2).

(4) Prompt Appointment of Counsel.

(A) The policy monitor shall review the local indigent defense plans and determine if they require:

(i) Counsel to be appointed for indigent defendants within one working day of receipt of the request for counsel in counties with a population of 250,000 or more, or three working days in other counties;

(ii) For juveniles not represented at the initial detention hearing, either immediate appointment of counsel or an order requiring the person having custody over the child to retain counsel if the person with custody is not found to be indigent;

(iii) For juveniles, that counsel to be appointed within five working days of the service on the child of the petition if the child's custodian is found indigent.

(B) The policy monitor shall check for documentation indicating that:

(i) Counsel was appointed for arrestees within one working day of receipt of the request for counsel in counties with a population of 250,000 or more, or three working days in other counties; and

(ii) Counsel was appointed within one day of the detention hearing for in-custody juveniles and within five working days of service of the petition on the juvenile for out-of-custody juveniles.

(5) Attorney Selection Process.

(A) The policy monitor shall review the local indigent defense plans and determine if they:

(i) Include an attorney selection method; and

(ii) Specify who is authorized to make appointments, what appointment lists are used, and a description of when an attorney on the list may be skipped, if applicable.

(B) The policy monitor shall check for documentation indicating:

(i) In the case of a contract defender program, that all requirements of §§174.10 - 174.25 of this title are met;

(ii) That attorney selection process actually used matches what is stated in the indigent defense plans; and

(iii) The number of appointments in the policy monitor's sample per attorney at each level (felony, misdemeanor, juvenile, and appeals) during the period of review, the percentage share of appointments represented by the top 10% of attorneys accepting appointments.

(6) Payment Process.

(A) The policy monitor shall review the local indigent defense plans and determine if they include:

(i) An attorney fee schedule;

(ii) Procedures for paying attorneys, experts, and investigators in accordance with the fee schedule; and

(iii) Procedures to reimburse expert and investigative expenses incurred without prior court approval when the expenses are reasonable and necessary.

(B) The policy monitor shall check for documentation indicating that the county has established a process for collecting and reporting itemized indigent defense expense and case information.

(d) Report.

(1) Report Issuance. The policy monitor shall issue a report to the program director within 30 days of the on-site monitoring visit to a county, unless a documented exception is provided by the director, with an alternative deadline provided, not later than 90 days from the on-site monitoring visit. The report shall contain each finding of noncompliance.

(2) County Response. Within 60 days of the date the report is issued by the policy monitor, the program director shall respond in writing to each finding of noncompliance, and shall describe the proposed corrective action to be taken by the county. The county may request the director to grant an extension of up to 60 days.

(3) Follow-up Visits. The policy monitor shall conduct an additional on-site visit to counties where the report included significant noncompliance findings. The follow-up visit shall occur within 12 months following receipt of a county's response to the report. The policy monitor shall review a county's implementation of corrective actions and shall report to the county and Task Force any remaining issues not corrected.

(4) Noncompliance. If a county fails to correct any noncompliance findings, the Task Force may impose a remedy under §173.308 of this title.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900176
Wesley Shackelford
Special Counsel
Texas Judicial Council
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 936-6994

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TITLE 16. ECONOMIC REGULATION

PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 45. MARKETING PRACTICES
SUBCHAPTER E. MISCELLANEOUS
DIVISION 1. DELINQUENT LIST

The Texas Alcoholic Beverage Commission (commission) proposes the repeal of §45.121, relating to credit law violations by retailers, wholesalers and distributors and proposes new §45.121, which will replace the repealed section.

Section 102.32 of the Texas Alcoholic Beverage Code (Code) provides that no wholesaler may sell and no retailer may purchase liquor except for cash or on terms requiring payment on or before the 25th of the month for purchases made between the 1st and the 15th of the month and on or before the 10th day of the following month for purchases made between the 16th and the last day of the month. The section requires records of deliveries and purchases. The section requires a wholesale dealer to immediately report to the commission when a retailer becomes delinquent on an account, and prohibits sales of any liquor to a retailer who is delinquent until the account is paid in full and cleared from the commission's records. An account becomes delinquent under subsection (d) of the statute if it is not paid as required by subsection (c). A wholesale dealer who violates the section commits an offense under the Code.

Existing §45.121 is being repealed because it is no longer necessary after the adoption of proposed new §45.121.

The proposed new section reorganizes the content of the existing rule and updates the text of the rule to a plain language standard and equalizes the duties of sellers and retailers for avoiding credit law violations.

New subsection (a) states the purpose of the new rule section.

New subsection (b) provides definitions used in the new rule.

New subsection (c) contains the requirements for invoices. It does not contain substantive revisions, but it does provide that records may be maintained electronically or in an internet based inventory system, reflecting updated business practices.

New subsection (d) provides that it is a violation of the rule to make a delinquent payment. It also provides that a retailer whose permit is cancelled, expires, is suspended or placed in suspense while on the delinquent list may be disqualified from receiving a new license or permit until the delinquency is satisfied. This new provision is intended to discourage retailers from abusing credit restrictions by imposing adverse consequences in future licensing decisions based on past abusive practices.

New subsection (e) provides a requirement that violations and payment be reported by sellers, and makes a failure to report a violation. The existing rule provides no violation for a seller who fails to report.

New subsection (f) prohibits sellers from selling or delivering liquor to any retailer location for a retailer that appears on the delinquent list. It makes a sale a violation of the section. The existing rule provides no violation for a seller who sells to a retailer on the delinquent list.

New subsection (g) prohibits a retailer from purchasing or accepting the delivery of liquor while on the delinquent list. It makes a purchase a violation of the section. The existing rule provides no violation for a retailer who purchases or accepts delivery of liquor while on the delinquent list.

New subsection (h) provides an exception to a retailer who has a good faith dispute regarding whether a violation of the section occurred.

New subsection (i) provides a penalty for repeat violations of the section for both retailers and sellers.

New subsection (j) relates to the publication of the delinquent list by the commission. The time requirements are provided by §102.32 of the Code. The remainder of the subsection provides the public with where to find the list and when it is published and updated.

Charlie Kerr, Chief Financial Officer, has determined that for the first five years that the proposed new rule is in effect there will be no fiscal impact on units of state or local government as a result of enforcing and administering the section as proposed.

Mr. Kerr has determined that for the first five years that the proposed new rule is in effect there will be a fiscal impact on small and micro-businesses and individuals who fail to comply with the sections. There will be no fiscal impact on small and micro-business and individuals who comply with the sections.

Sherry Cook, Assistant Administrator, has determined that for each of the first five years that new §45.121, is in effect the public will benefit from the adoption of the proposed clarifications made, equalization of responsibilities of sellers and retailers, and the conformance of the rule to the intent of the statute to prevent credit violations between the wholesaler and retailer tiers.

Comments on the proposed repeal and new rule may be addressed to Joan Carol Bates, Deputy General Counsel, Texas Alcoholic Beverage Commission, P.O. Box 13127, Austin, Texas 78711. Comments will be accepted for 30 days following publication of the repeal and proposed new rule in the *Texas Register.*

16 TAC §45.121

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Alcoholic Beverage Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal of the existing rule and adoption of the new rule are authorized by §5.31 and §102.32 of the Alcoholic Beverage Code (Code). Section 5.31 gives the commission authority to prescribe and publish rules necessary to carry out the provisions of the Code. Section 102.32 provides the specific authority to adopt these rules to give effect to the section.

Cross Reference: Sections 5.31 and 102.32 of the Alcoholic Beverage Code are affected by the repeal of the existing rule and the proposed new rule.

§45.121. Delinquent List.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900205
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 206-3204

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16 TAC §45.121

The repeal of the existing rule and adoption of the new rule are authorized by §5.31 and §102.32 of the Alcoholic Beverage Code (Code). Section 5.31 gives the commission authority to prescribe and publish rules necessary to carry out the provisions of the Code. Section 102.32 provides the specific authority to adopt these rules to give effect to the section.

Cross Reference: Sections 5.31 and 102.32 of the Alcoholic Beverage Code are affected by the repeal of the existing rule and the proposed new rule.

§45.121. Credit Restrictions and Delinquent List for Liquor.

(a) Purpose. This rule implements §§102.32, 11.61(b)(2) and 11.66 of the Texas Alcoholic Beverage Code (Code).

(b) Definitions.

(1) Alcoholic beverage--As used in this section includes only liquor, as that term is defined in §1.04 of the Code.

(2) Delinquent payment--A financial transaction or instrument that fails to provide payment in full or is returned to the Seller as unpaid for any reason.

(3) Retailer--A package store permittee, wine only package store permittee, private club permittee, private club exemption certificate permittee, mixed beverage permittee, or other retailer, and their agents, servants and employees.

(4) Seller--A wholesaler, class B wholesaler, winery, wine bottler, or local distributor and their agents, servants and employees.

(c) Invoices. A delivery of alcoholic beverages by a Seller, to a Retailer, must be accompanied by an invoice of sale showing the name

and permit number of the Seller and the Retailer, a full description of the alcoholic beverages, the price and terms of sale, and the place and date of delivery.

(1) The Seller's copy of the invoice must be signed by the Retailer to verify receipt of alcoholic beverages and accuracy of invoice.

(2) The Seller and Retailer must retain invoices in compliance with the requirements of §206.01 of the Code.

(3) Invoices may be created, signed and retained in an electronic or internet based inventory system, and may be retained on or off the licensed premise.

(d) Delinquent Payment Violation. A Retailer who makes a delinquent payment to a Seller for the delivery of alcoholic beverages violates this section unless an exception applies.

(1) A Retailer who violates this section must pay a delinquent amount, and a Seller may accept payment, only in cash or cash equivalent financial transaction or instrument.

(2) A Retailer whose permit or license is cancelled for cause, voluntarily cancelled, expires, suspended or placed in suspension while on the delinquent list may be disqualified from applying for or being issued an original or renewal permit or license. For purposes of this rule, the Retailer includes all persons who were owners, officers, directors, equity interest holders and shareholders of the Retailer at the time the delinquency occurred.

(e) Reporting Violation and Payment; Failure to Report.

(1) A report of a violation or payment must be made by completing all information required on the form provided by the commission for this purpose. Reporting forms may be obtained on the commission's public web site at http://www.tabc.state.tx.us.

(2) Sellers are required to report each violation to the commission electronically to credit.law@tabc.state.tx.us, or by submitting the appropriate forms in writing by fax or by mail to the number or address listed on the form.

(3) Sellers are required to report a Notice of Payment when a Retailer makes payment in full for a previously reported violation. The report may be filed electronically to credit.law@tabc.state.tx.us, or by submitting the appropriate forms in writing or by fax or mail to the number or address listed on the form.

(4) All reports of violations or payment under this subsection must be made to the commission within two business days from the date the violation is discovered by the Seller.

(5) A Seller who fails to report a violation or a payment as required by this subsection is in violation of this section.

(f) Prohibited Sales and Delivery.

(1) Sellers are prohibited from selling or delivering alcoholic beverages to any licensed location of a Retailer who appears on the commission's Delinquent List from the date the violation appears on the Delinquency List until the Release Date on the Delinquent List, or the Retailer no longer appears on the Delinquent List.

(2) A sale or delivery of alcoholic beverages prohibited by this section is a violation of this section.

(g) Prohibited Purchase or Acceptance.

(1) A Retailer who appears on the commission's Delinquency List is prohibited from purchasing or accepting delivery of alcoholic beverages from any source to any of Retailer's licensed locations from the date the violation appears on the Delinquency List until the Release Date on the Delinquent List or until the Retailer no longer appears on the Delinquent List.

(2) A prohibited purchase or acceptance of a delivery of alcoholic beverages is a violation of this section.

(h) Exception. A Retailer who wishes to dispute a violation of this section or inclusion on the commission's Delinquent List, based on a good faith dispute between the Retailer and the Seller may file a detailed written statement with the commission and the Seller explaining the basis of the dispute. The Retailer must immediately notify the commission of the resolution of a dispute under this subsection.

(i) Penalty for Violation. An action to cancel or suspend a permit or license may be initiated under §11.61(b)(2) of the Code for repeat violations of this section.

(j) Delinquent List.

(1) The Delinquent List is published bi-monthly on the commission's public web site at http://www.tabc.state.tx.us. An interested person may receive the Delinquent List by electronic mail each date the Delinquent List is published by registering for this service online.

(2) The Delinquent list will be published the 5th day of each month for purchases made from the 1st to the 15th day of the preceding month, for which payment was not made on or before the 25th day of that month. The Delinquent list will be published the 20th day of the month for purchases made between the 16th and the last day of the preceding month for which payment was not made on or before the 10th day of the month.

(3) The Delinquent List is effective at 12:01 A.M. on the date of publication.

(4) The Delinquent List is updated continuously to reflect Notice of Payments received, each day the commission is open during normal business hours. The Release Date is the date the commission enters the Notice of Payment onto the Delinquent List.

(k) Calculation of Time. A due date under this section or §102.32(c) of the Code that would otherwise fall on a Saturday, Sunday or a state or federal holiday, will be the next regular business day. A payment sent by U.S. postal service or other mail delivery service is deemed made on the date postmarked or proof of date delivered to the mail delivery service. A payment hand delivered to an individual authorized to accept payment on behalf of the Seller is deemed made when the authorized individual takes possession of the payment.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900206
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 206-3204

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 61. CHRONIC DISEASES
SUBCHAPTER E. CHILDREN'S OUTREACH HEART PROGRAM

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes the repeal of §§61.71 - 61.83, and new §§61.71 - 61.83 concerning the Children's Outreach Heart Program (COHP).

BACKGROUND AND PURPOSE

The COHP provides prediagnostic cardiac screening and follow-up services to individuals less than 21 years of age who may have heart disease or defects. The COHP contractor provides routine clinic services, including a comprehensive history and physical exam, as well as laboratory studies, electrocardiograms, chest x-rays, and an individual care plan for each client who is referred by the clinic to a secondary center.

The proposed repeals and new rules will reorganize and update information, delete and revise language, and make grammatical corrections to improve flow, accuracy, and clarity.

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 61.71 - 61.83 have been reviewed, and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

The proposed rules update references to the legacy agency, now part of the Health and Human Services Commission, reflect the department's name change from "Texas Department of Health" to "Department of State Health Services." References to the compliance document reflect the document's name change from "Quality Care: Client Services Standards for Public Health and Community Clinics" dated June 1997 to "Department of State Health Services Standards for Public Health Clinic Services" dated August 2004.

The proposed §61.71 includes the general purpose of the program and refers to confidentiality of information.

The proposed §61.72 includes new definitions that improve and clarify the rules.

The proposed §61.73 includes language necessary for clarification of the COHP client services eligibility requirements.

The proposed §61.74 includes language necessary for clarification of COHP contractor funding requirements.

The proposed §61.75 includes language necessary for clarification of the contractor's responsibility to maximize program income and establish client co-payment policy.

The proposed §61.76 includes language necessary for clarification of contractor staff responsibilities.

The proposed §61.77 includes language necessary for clarification of requirements of clinic facilities and equipment and compliance with the document "Department of State Health Services Standards for Public Health Clinic Services" dated August 2004.

The proposed §61.78 includes language necessary for clarification of required clinical services and contractor staff responsibilities.

The proposed §61.79 includes language necessary for clarification of the contractor and clinic staff responsibility for coordination of community services.

The proposed §61.80 includes language necessary for clarification of the clinic(s) and contractor responsibility to maintain client rights.

The proposed §61.81 includes language necessary for clarification of the responsibility of clinic(s) to maintain a tracking system that monitors each client's health status and use of health care services.

The proposed §61.82 includes language necessary for clarification of the responsibility of clinic(s) to comply with HIPAA records management requirements and the document "Department of State Health Services Standards for Public Health Clinic Services," dated August 2004.

The proposed §61.83 includes language necessary for clarification of the contractor's responsibility for internal review, evaluation of program services, and reporting in compliance with department policy and the document "Department of State Health Services Standards for Public Health Clinic Services" dated August 2004.

FISCAL NOTE

Jann Melton-Kissel, RN, MBA, Director, Specialized Health Services Section, has determined that for each year of the first five-year period that the sections will be in effect, there will be no fiscal impact to state or local governments as a result of enforcing and administering the sections as proposed. The repeals and new rules are intended to clarify, update, and strengthen the subchapter, and are not anticipated to be controversial or have significant fiscal impact to the department or local government.

MICRO-BUSINESS AND SMALL BUSINESS IMPACT ANALYSIS

Ms. Melton-Kissel has also determined that there will be no effect on small businesses or micro-businesses required to comply with the sections as proposed, because neither small businesses nor micro-businesses affected by the COHP rules will be required to alter their business practices in order to comply with the rules, and an economic impact statement and regulatory flexibility analysis are not required. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Ms. Melton-Kissel has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the rules. The public benefit anticipated as a result of enforcing or administering the rules is improved accuracy and consistency in the rules, and more accurate interpretation of their intent. In addition, the new rules will allow the program to function more efficiently and effectively.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment

or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted by mail to Angela Carrasco, Purchased Health Services Unit, Mail Code 1938, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347, by telephone at (512) 458-7111, extension 3067, or by email at angela.carrasco@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

25 TAC §§61.71 - 61.83

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Department of State Health Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The proposed repeals are authorized by the Health and Safety Code, §39.003, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules necessary to define the scope of the children's outreach heart program; Government Code, §531.0055(e), and the Health and Safety Code, §1001.075, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The proposed repeals affect Government Code, Chapter 531; and Health and Safety Code, Chapter 1001.

§61.71. Purpose.

§61.72. Definitions.

§61.73. Eligibility for Client Services.

§61.74. Contractor Staff.

§61.75. Clinic Facilities and Equipment.

§61.76. Services.

§61.77. Records Management.

§61.78. Patient Rights.

§61.79. Program Income and Patient Co-payment.

§61.80. Tracking/follow-up.

§61.81. Coordination of Community Services.

§61.82. Evaluation.

§61.83. Funding of Children's Outreach Heart Program Contractor.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 16, 2009.

TRD-200900214
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 458-7111 x6972

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25 TAC §§61.71 - 61.83

STATUTORY AUTHORITY

The proposed new rules are authorized by the Health and Safety Code, §39.003, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules necessary to define the scope of the children's outreach heart program; Government Code, §531.0055(e), and the Health and Safety Code, §1001.075, which authorizes the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The proposed new rules affect Government Code, Chapter 531; and Health and Safety Code, Chapter 1001.

§61.71. General Information.

(a) Purpose. The purpose of this subchapter is to establish rules for the Children's Heart Outreach Program (COHP). By authority granted in Health and Safety Code, Chapter 39, COHP provides:

(1) prediagnostic cardiac screening and follow-up evaluation services to persons less than 21 years of age who are from low-income families and who may have heart disease and/or defects; and

(2) training to local physicians and public health nurses in screening and diagnostic procedures for heart disease and/or defects.

(b) Confidentiality of Information.

(1) All information submitted, as required by this chapter, may be verified at the discretion of the Department of State Health Services (department) with or without notice to the applicant, client, or contractor staff of COHP services. Information required by this chapter and received by the department is kept confidential to the extent authorized by law.

(2) Information may be disclosed in summary, statistical, or other forms that do not identify particular individuals.

§61.72. Definitions.

The following words and terms when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

(1) Applicant--A person making an initial application for Children's Outreach Heart Program (COHP) services.

(2) Bona fide resident--A person who:

(A) is physically present within the geographic boundaries of the state;

(B) has an intent to remain within the state; and

(C) maintains an abode within the state (i.e., house or apartment, not merely a post office box).

(3) Cardiac--Of, relating to, situated near, or acting on the heart.

(4) Cardiac outreach clinic (clinic)--A primary or secondary level health care facility staffed by local and secondary or tertiary level outreach personnel and equipped to perform the following functions:

(A) screening and assessment of children for cardiac disease;

(B) identification and referral of children with cardiac disease to the closest appropriate tertiary center for definitive diagnostic procedures and, if needed, surgery; and

(C) management of children with heart disease to include development of an individual care plan, tracking, and periodic follow-up and coordination with local case management services providers, if available.

(5) CHIP--The Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. §§1397aa, *et seq.*)

(6) Client--A person who has applied for program services and who meets all COHP eligibility requirements and has been determined to be eligible for program services.

(7) Contractor--One or more individuals or entities selected by the department to provide Children's Outreach Heart Program services, including departments, agencies, boards, educational institutions, county governments, municipal governments, states, or the United States.

(8) Co-pay/co-payment--A cost-sharing arrangement in which a client pays a specified charge for a specified health care service, usually at the time the service is provided.

(9) CSHCN Services Program--The Children with Special Health Care Needs Services Program; Health and Safety Code, Chapter 35.

(10) Department--The Department of State Health Services.

(11) Federal Poverty Level (FPL)--The minimum income needed by a family for food, clothing, transportation, shelter, and other necessities in the United States, according to the United States Department of Health and Human Services, or its successor. The FPLs vary according to family size, and after adjustment for inflation, are published annually in the *Federal Register*.

(12) Heart disease or defect--An abnormality or disease of the heart or major blood vessel(s) near the heart.

(13) HIPAA--The Health Insurance Portability and Accountability Act of 1996; 42 U.S.C. §§1320d-2 *et seq.*

(14) Individual care plan--A comprehensive plan for the provision of needed care, support and services to an individual client by designated service providers and by members of the client's family and personal support system.

(15) Medical home--A respectful partnership between a client, the client's family as appropriate, and the client's primary health care setting. A medical home is family-centered health care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. A medical home includes a licensed medical professional who accepts responsibility for the provision and/or coordination of primary, preventive, and/or specialty care for a client, and coordination of care with other community services providers.

(16) Outreach physician--A board-certified pediatric cardiologist responsible for supervising the clinic(s).

(17) Physician--A person licensed by the Texas Medical Board to practice medicine in the State of Texas.

(18) Program--The Children's Outreach Heart Program (COHP).

(19) Program income--All revenues received by a contractor as a result of providing services under this subchapter, including third party payments, such as Medicaid, CHIP, CSHCN Services Program, and private insurance; and client co-payments.

(20) Registered nurse (RN)--A person currently licensed by the Texas Board of Nursing to practice professional nursing in the State of Texas.

§61.73. Eligibility for Client Services.

(a) An applicant shall meet all of the following requirements to be eligible for benefits from the COHP:

(1) have a heart disease and/or defect;

(2) be under 21 years of age; and

(3) be a bona fide resident of the State of Texas.

(b) An applicant's family income shall meet one of the following financial requirements to be eligible for benefits from the COHP:

(1) the family's income level is at or below 200% of the FPL; or

(2) the family's income level exceeds 200% of the FPL, but the applicant is not eligible for public assistance with medical expenses.

(c) An applicant whose family income exceeds 200% of the FPL may be required to pay a co-payment based on family income and household size.

§61.74. Funding of the COHP Contractor.

(a) The department will provide COHP services through a contractor selected in compliance with the department's contracting and procurement procedures.

(b) An entity seeking funding as a contractor must demonstrate in its proposal that:

(1) provision of program services in the designated community(ies) and surrounding geographic area would meet a recognized need;

(2) services to be provided are not available to the identified population due to distance or a lack of access, resulting in a barrier to quality health care for the community(ies);

(3) the local community(ies), including the local or county medical society(ies), support(s) the need for the clinic(s); and

(4) proposed services can be integrated into the local health care system.

(c) The contractor may receive cost-based or fee-for-service reimbursement for the following:

(1) travel to the clinic(s) by the outreach physician and team members;

(2) the salaries of local and/or outreach staff necessary for administration of the clinic(s) or provision of clinic services;

(3) physician services;

(4) facility use fees; and

(5) laboratory, radiology, electrocardiography, and other procedures necessary for assessment and screening of clients.

§61.75. Program Income and Client Co-payment.

(a) The contractor shall maximize program income by billing third-party payers for the clients served, including CSHCN Services Program, Medicaid, CHIP, and private insurance. The contractor shall ensure that clients who may be eligible for Medicaid, CHIP, and/or CSHCN Services Program are referred for eligibility determination.

(b) The contractor shall develop a co-payment policy concerning program services provided to clients whose family incomes exceed 200% of the FPL, but who are not eligible for public assistance with medical expenses, including the following:

(1) co-payments shall be based on family income and household size; and

(2) any schedule of sliding scale co-payments shall be approved by the department prior to implementation.

(c) No client who meets age and medical eligibility criteria will be denied services on the basis of inability to pay.

§61.76. Contractor Staff.

(a) The contractor shall assure that clients have access to:

(1) a coordinator who communicates with clinic staff as frequently as necessary to:

(A) process referrals;

(B) schedule appointments;

(C) coordinate the activities of the clinics, if more than one exists; and

(D) track clients, if follow-up is necessary;

(2) an outreach physician who is a board-certified pediatric cardiologist responsible for:

(A) supervising the clinic(s);

(B) coordinating the screening and assessment process;

(C) developing an individual care plan for each client identified with heart disease and/or defect who is referred by the clinic to a secondary or tertiary center;

(D) making appropriate recommendations for referral, when necessary;

(E) sending follow-up letters to referral sources;

(F) maintaining appropriate medical records for clients; and

(G) assuming responsibility for provision of all services that would otherwise have been provided by an RN if no RN is on site.

(3) an RN with at least one year of clinical pediatric experience, preferably with pediatric cardiology experience, who shall be on site during clinic hours; and

(4) a social worker licensed by the department, or other clinic staff member, who identifies the need for and makes referrals to case management services as documented in clients' medical records.

§61.77. Clinic Facilities and Equipment.

(a) The clinic(s) shall assure that adequate supplies, space, and equipment are available to:

(1) measure vital signs for children of all ages;

(2) perform age-appropriate anthropometric testing on all clients; and

(3) obtain electrocardiograms and chest x-rays on all clients.

(b) All equipment and supplies used shall be appropriate for the client's age and level of development.

(c) The contractor shall obtain routine lab work. If unable to provide echocardiography or x-rays directly, the contractor will obtain these services through sub-contractual or other arrangements.

(d) The clinic(s) shall be conducted in compliance with the document "Department of State Health Services Standards for Public Health Clinic Services" dated August 2004, or its successor, specifically including the following requirements:

(1) the clinic(s) shall be accessible to the target population;

(2) clinic facilities shall be appropriate for pediatric care;

(3) clinic services shall be provided in settings designed to ensure client comfort, safety, and privacy, and to expedite the work of the staff; and

(4) the contractor or clinic site(s) shall meet any licensure or certifications required for clinic operations in the State of Texas.

§61.78. Services.

(a) Routine clinic services must include a comprehensive history and physical exam.

(b) Additional services, as determined necessary by the physician, may include:

(1) laboratory studies;

(2) electrocardiograms;

(3) chest x-rays; and

(4) echocardiography may be performed if the results are of acceptable quality for pediatric clients and reviewed and interpreted by the outreach physician responsible for the clinic.

(c) The outreach physician shall develop an individual care plan for each client identified with heart disease and/or defect who is referred by the clinic to a secondary or tertiary center.

(d) The clinic staff shall work as a team in conjunction with the client, family, the referral source, and the secondary or tertiary center to develop the individual care plan.

(e) Clinic staff shall track clients if the individual care plan requires follow-up.

(f) Clinic services shall be integrated into the overall service needs of each client through clinic staff cooperation and sharing of information with local case management services providers, if available.

(g) The clinic(s) shall ensure that translation and interpreter services are available to all clients who are unable to communicate effectively in English, and shall provide services in a culturally sensitive manner.

(h) The following clinical services shall not be approved or reimbursed by the program at cardiac outreach clinics:

(1) echocardiography for routine screening purposes;

(2) exercise testing;

(3) catheterization; and

(4) surgery.

§61.79. Coordination of Community Services.

(a) The contractor shall inform the local communities, including local physicians, community service groups, and the general public, of the clinic and its services within three months of a funding award.

(b) The contractor shall provide a report addressing the number of clients served, services provided, and diagnoses to the local or county medical society annually.

(c) The outreach physician shall communicate with the client's local or primary physician, medical home, or referral source concerning the client's history, physical exam, and diagnosis and must involve the local physician in the development of the client's individual care plan.

(d) The contractor shall encourage local physicians to participate in the clinic(s).

(e) The outreach physician and clinic staff should provide local physicians, and other community professionals involved with the clinic population, with continuing education in the areas of diagnosis, evaluation, and treatment of children with suspected and confirmed cardiovascular disease.

(f) The clinic(s) shall coordinate services with other community activities in an effort to facilitate the public's access to the clinic(s) and other community services, and to prevent duplication of services.

(g) If local pediatric cardiology expertise becomes available that meets the needs expressed in the clinic proposal and is community-supported, the contractor shall phase out services in coordination with the local providers.

§61.80. Client Rights.

(a) The clinic(s) shall provide services in a timely manner.

(b) The clinic(s) shall assure confidentiality of client information and provide information to clients and their families regarding its policies.

(c) Facilities within the clinic(s) shall be arranged or designed so that services are provided in a manner that protects the dignity and privacy of clients and their families.

(d) The clinic(s) shall provide services in a nondiscriminatory manner, complying with civil rights statutes, regulations, and the department's policies.

(e) The contractor or clinic staff shall not coerce individuals into services, nor may participation in one service or program be a requirement for eligibility for another service.

(f) The clinic(s) shall provide services in ways that can be understood by clients and their families including, but not limited to, addressing the needs of clients with limited English proficiency, as required by Title VI of the Civil Rights Act of 1964.

(g) The contractor shall either post or provide information in writing to clients and their families concerning procedures available to address concerns about care received or alleged violation of clients' and their families' rights.

§61.81. Tracking and Follow-up.

(a) The clinic(s) shall utilize a tracking system to monitor each client's health status and use of health care services. The tracking system shall:

(1) schedule contacts with the client and their family at regular intervals according to program guidelines and protocols, and coordinate with other services and opportunities as needed;

(2) monitor the status of the individual care plan, including compliance and the need for revisions;

(3) monitor broken appointments and establish a system for rescheduling appointments;

(4) alert staff for follow-up concerning conditions identified as priorities for care;

(5) track referrals made to other providers or agencies; and

(6) follow-up with the client and the client's family, as appropriate, to ensure that services were accessed.

(b) If a client moves out of the identified service area, clinic(s) shall attempt to maintain continuity of care by providing the client and the client's family with information on available services, including case management, in the area to which they are relocating.

(c) The clinic(s) shall evaluate the effectiveness of services provided on an ongoing basis and shall adjust the individual care plan when needed to maximize the client's health.

§61.82. Records Management.

(a) The clinic(s) shall utilize an organized client record system.

(b) The clinic(s) shall comply with laws and regulations regarding confidentiality of client records, including HIPAA. In addition:

(1) records shall be confidential and secure;

(2) records shall be available to the client, family, or guardian upon request with a signed release of information; and

(3) the clinic(s) shall implement a policy that delineates guidelines for the release of confidential information.

(c) The clinic(s) shall maintain a complete and accurate record for each client.

(d) The clinic(s) shall implement a written policy regarding retention and proper disposal of client records.

(e) The clinic(s) shall comply with records management requirements in the document "Department of State Health Services Standards for Public Health Clinic Services," dated August 2004, or its successor.

§61.83. Evaluation.

(a) The contractor shall have a plan for internal review and evaluation of program services to assure the provision of quality services in compliance with "Department of State Health Services Standards for Public Health Clinic Services," dated August 2004, or its successor and other department policies.

(b) The contractor shall submit reports to the department in a format and include content specified by the department. The reports will be used as a paper audit to assure that the contractor is performing in accordance with the contract. The department shall also conduct on-site visits when deemed necessary to evaluate the contractor's adherence to the department's guidelines and requirements. The contractor typically will receive a two-week notice and will be consulted for scheduling purposes.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 16, 2009.

TRD-200900215
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 458-7111 x6972

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SUBCHAPTER F. DIABETES REGISTRY

25 TAC §61.91

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes new §61.91 concerning the establishment of a diabetes pilot project that will create an electronic registry to track glycosylated hemoglobin levels and to govern the format and method of collecting glycosylated hemoglobin data.

BACKGROUND AND PURPOSE

The new section is necessary to comply with Chapter 706, uncodified, (House Bill (HB) 2132) passed by the 80th Texas Legislature, 2007, that requires the department to establish a diabetes mellitus registry pilot program. The rule requires a clinical laboratory located in the participating public health district to submit to the district and the department the results of each glycosylated hemoglobin test that the laboratory performs. Not later than December 1, 2009, the department shall submit to the legislature a report concerning the effectiveness and recommendations for the program. This rule and the statute that supports it, expire in September 2010.

SECTION-BY-SECTION SUMMARY

New §61.91(a) describes the purpose of the Diabetes Mellitus Registry Pilot Program. New §61.91(b) defines the terms "Diabetes Mellitus" and "Glycosylated hemoglobin test." New §61.91(c) provides language stating that the pilot program will be conducted by the San Antonio Metropolitan Health District, and provides language informing the clinical laboratory staff where to report glycosylated hemoglobin test results. New §61.91(d) provides language stating what information shall be reported for each glycosylated hemoglobin test result and describes the protocol to ensure confidentiality. New §61.91(e) and §61.91(f) state when reporting of glycosylated hemoglobin test results shall begin and the date when reporting will end.

FISCAL NOTE

Casey Blass, Section Director, Disease Prevention and Intervention Section, has determined that for each year of the first five years that the section will be in effect, there will be no fiscal implications to state government as a result of enforcing or administering the section as proposed because the legislation states "the participating public health district is solely responsible for the costs of establishing and administering the pilot program." (Chapter 706, uncodified, 80th Texas Legislature, 2007, Section 1(f)). There are fiscal implications for the San Antonio Metropolitan Health District, who will administer this program. These implications apply only in the first two years of the program because the legislation expires in September 2010 (Chapter 706, uncodified, 80th Texas Legislature, 2007, Section 5). During this period the estimated cost to the district shall be approximately one full time staff person to administer and implement this program and a contractor to collect and analyze the data, an annual cost of approximately $200,000.

SMALL AND MICRO-BUSINESS ECONOMIC IMPACT STATEMENT

Mr. Blass has also determined that there will be no effect on small businesses or micro-businesses required to comply with the section as proposed. This was determined by interpretation of the rule that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the section. 100% of the required glycosylated hemoglobin tests will be reported by clinical laboratories, which are not small businesses or micro-businesses.

Requiring reporting from clinical and hospital laboratories is the only way to accomplish the important public health purpose of Chapter 706, uncodified, 80th Legislature, 2007. The department chose the San Antonio Metropolitan Health District because it was the only district that met the requirements set in Section 1(c) of the Chapter.

PUBLIC BENEFIT

In addition, Mr. Blass has also determined that for each year of the first five years that the section is in effect the public will benefit from adoption of the section. The institutions and individuals responsible for reporting the glycosylated hemoglobin tests will have clear guidance on what is reportable; the public health community will be able to assess methods to promote the prevention and improve control of diabetes; and the general public will be better served by the department as it fulfills its responsibility to monitor, track, and assess the trends and economic costs related to the burden of diabetes.

ECONOMIC COSTS TO PERSONS

In addition, Mr. Blass has also determined that for each year of the first five years that the section is in effect, there is a cost per report for the clinical laboratory. A major laboratory informed the department that the anticipated economic cost to comply with the section as proposed is up to $25,000. This cost may be subsidized by the San Antonio Metropolitan Health District, which intends to provide reporting labs with software to facilitate reporting.

LOCAL EMPLOYMENT IMPACT

There is no anticipated affect on local employment.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed rule does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and,

therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Cassandra DeLeon, Director, Texas Diabetes Council/Program, Department of State Health Services, P. O. Box 149347, Austin, Texas 78714-9347, (512) 458-7111 extension 3549 or by email to Cassandra.Deleon@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rule has been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed new section is authorized by Chapter 706, uncodified, (HB 2132) 80th Texas Legislature, 2007, Section 2, which requires the Executive Commissioner of the Health and Human Services Commission to adopt rules necessary to implement and govern the format and method of collecting glycosylated hemoglobin data; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of the health and human services by the department and for the administration of Health and Safety Code, Chapter 1001.

The proposed new section affects Chapter 706, uncodified, (HB 2132) 80th Texas Legislature, 2007; Health and Safety Code, Chapter 1001; and Government Code, Chapter 531.

§61.91. Diabetes Mellitus Glycosylated Hemoglobin Test Registry Pilot.

(a) Purpose. The Diabetes Mellitus Registry Pilot Program, Statute Chapter 706, uncodified, (House Bill 2132) 80th Texas Legislature, 2007 requires the establishment of a pilot program for the reporting of glycosylated hemoglobin tests.

(b) Definitions. The following words and terms when used in this subchapter shall have the following meanings unless the context clearly states otherwise.

(1) Glycosylated hemoglobin test--A measurement of a form of hemoglobin used primarily to identify the average plasma glucose concentration over prolonged periods of time.

(2) Diabetes Mellitus--A syndrome characterized by disordered metabolism and abnormally high blood sugar (hyperglycemia) resulting from insufficient levels of the hormone insulin or reduced insulin sensitivity.

(c) Where to report. The pilot program is being conducted in the San Antonio Metropolitan Health District. This jurisdiction meets the requirements of the statute. A clinical laboratory located in the participating public health district shall submit to the district and the department the results of each glycosylated hemoglobin test that the laboratory performs.

(d) Reportable information requirements.

(1) The test result information that shall be reported for each glycosylated hemoglobin test performed within the San Antonio Metropolitan Health District service area is as follows: glycosylated hemoglobin value; patient name, address, telephone number, age, date of birth, sex, race and ethnicity; date of test, location of test site, diabetes diagnosis; and physician name, address, and telephone number.

(2) Additional information necessary to determine the trends and public health costs of diabetes control shall also be reported if requested.

(3) Reports, records, and information are confidential and are not subject to disclosure under Government Code, Chapter 552, are not subject to subpoena, and may not otherwise be released. The reports, records, and information obtained are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this pilot program.

(e) When to report. Reporting shall begin on the effective date of this rule. Glycosylated Hemoglobin test results shall be reported within 5 calendar days.

(f) This rule expires September 1, 2010.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900195
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 458-7111 x6972

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CHAPTER 411. STATE MENTAL HEALTH AUTHORITY RESPONSIBILITIES
SUBCHAPTER D. ADMINISTRATIVE HEARINGS OF THE DEPARTMENT IN CONTESTED CASES

25 TAC §§411.151 - 411.160, 411.162, 411.163

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Department of State Health Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Executive Commissioner of the Health and Human Services Commission (HHSC) on behalf of the Department of State Health Services (department) proposes the repeal of §§411.151 - 411.160, 411.162, and 411.163, concerning the administrative hearings for contested cases.

BACKGROUND AND PURPOSE

Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 411.151 - 411.160, 411.162, and 411.163 have been reviewed and the department has determined that reasons for adopting the sections no longer exist. Although these rules were needed at the time of adoption, when the Texas Department of Mental Health and Mental Retardation was in existence, HHSC has recently adopted new

rules in 1 TAC Chapter 357, Subchapter I, which address the same subject matter and would supersede these rules.

SECTION-BY-SECTION SUMMARY

Sections 411.151 - 411.160, 411.162, and 411.163 are being repealed in their entirety. The rules are no longer necessary because they are superseded by HHSC rules in 1 TAC Chapter 357, Subchapter I, regarding hearings under the Administrative Procedure Act.

FISCAL NOTE

Mike Maples, Assistant Commissioner for Mental Health and Substance Abuse Services, has determined that for each year of the first five-year period that the sections will be in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the sections as proposed.

SMALL AND MICRO-BUSINESS ECONOMIC IMPACT STATEMENT AND PERSONS AND LOCAL EMPLOYMENT

Mr. Maples has also determined that there will be no adverse economic impact on small businesses or micro-businesses required to comply with the sections as proposed. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the sections. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated impact on local employment. Therefore, an economic impact statement and regulatory flexibility analysis for small and micro-businesses are not required.

PUBLIC BENEFIT

Mike Maples has determined that for each year of the first five years the repeal of the sections is in effect, the public will benefit. The public benefit anticipated as a result of repealing the sections is that the department will maintain a clear, concise set of rules and avoid the potential for confusion from retaining rules that have no effect.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the repeals would not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposed repeal may be submitted in writing to Janet Fletcher, Department of State Health Services, Mail Code 2082, 909 West 45th Street, Austin, Texas 78751, or by email to janet.fletcher@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed repeals are authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the sections implements Government Code, §2001.039.

The proposed repeals affect the Government Code, Chapter 531; and Health and Safety Code, Chapter 1001.

§411.151. Purpose.

§411.152. Applicability and Scope of Rules.

§411.153. Definitions.

§411.154. Administrative Law Judge.

§411.155. Hearing Guidelines.

§411.156. Conduct of Hearings--General Requirements.

§411.157. Prehearing Procedure.

§411.158. Evidence and Depositions.

§411.159. Deliberation.

§411.160. Decisions.

§411.162. References.

§411.163. Distribution.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900189
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 458-7111 x6972

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CHAPTER 419. MENTAL HEALTH SERVICES--MEDICAID STATE OPERATING AGENCY RESPONSIBILITIES

SUBCHAPTER G. MEDICAID FAIR HEARINGS

25 TAC §419.301

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Department of State Health Services or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Executive Commissioner of the Health and Human Services Commission (HHSC), on behalf of the Department State Health Services (department), proposes the repeal of §419.301, concerning Medicaid Fair Hearings.

BACKGROUND AND PURPOSE

This rule, §419.301, adopted by the former Texas Department of Mental Health and Mental Retardation, primarily incorporates by reference the HHSC rules relating to Medicaid Fair Hearings. This separate, independent rule is not necessary to retain and is being proposed for repeal.

Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Section 419.301 has been reviewed and the department has determined that there is no need to retain the rule and is proposing its repeal.

The department offers Medicaid mental health services and notifies eligible clients of their right to a fair hearing when benefits or services are denied, delayed, terminated, reduced, or suspended. In the event that a client requests a fair hearing, the hearing is provided by the Appeals Division of HHSC, and is subject to the HHSC rules in 1 TAC Chapter 357, Subchapter A. Section 419.301 is redundant and unnecessary because it incorporates HHSC rules that apply when HHSC conducts the fair hearings for Medicaid clients receiving mental health services from the department.

SECTION-BY-SECTION SUMMARY

Section 419.301 is proposed for repeal as unnecessary because HHSC rules apply to Medicaid fair hearings conducted by HHSC.

FISCAL NOTE

Mike Maples, Assistant Commissioner for Mental Health and Substance Abuse Services, has determined that for each year of the first five-year period that the section will be in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the section as proposed.

SMALL AND MICRO-BUSINESS ECONOMIC IMPACT STATEMENT AND PERSONS AND LOCAL EMPLOYMENT

Mr. Maples has also determined that there will be no adverse economic impact on small businesses or micro-businesses required to comply with the section as proposed. This was determined by interpretation of the rules that small businesses and micro-businesses will not be required to alter their business practices in order to comply with the section. There are no anticipated economic costs to persons who are required to comply with the section as proposed. There is no anticipated impact on local employment. Therefore, an economic impact statement and regulatory flexibility analysis for small and micro-businesses are not required.

PUBLIC BENEFIT

Mr. Mike Maples has determined that for each year of the first five years the repeal of the section is in effect, the public will benefit. The public benefit anticipated as a result of repealing the section is that the department will maintain a clear, concise set of rules and avoid the potential for confusion from retaining a rule that is unnecessary and has no effect.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the repeal would not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and therefore, does not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposed repeal may be submitted in writing to Janet Fletcher, Department of State Health Services, Mail Code 2082, 909 West 45th Street, Austin, Texas 78751, or by email to janet.fletcher@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rule has been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The proposed repeal is authorized by Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. The review of the section implements Government Code, §2001.039.

The proposed repeal affects the Government Code, Chapter 531; and Health and Safety Code, Chapter 1001.

§419.301. Medicaid Fair Hearings.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900192
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 458-7111 x6972

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 363. FINANCIAL ASSISTANCE PROGRAMS

The Texas Water Development Board (Board) proposes this rulemaking to amend §363.1006 regarding Prioritization System, §363.1007 regarding Prioritization Criteria, §363.1206 regarding Pre-design Funding Option, §363.1207 regarding Prioritization System, and §363.1208 regarding Prioritization Criteria.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE PROPOSED RULES

The Board proposes this rulemaking to amend its current rules related to the application and prioritization process for the Board's commitment to provide financial assistance from its State Participation Account and Water Infrastructure Fund. The proposed amendments will clarify the prioritization process and will provide the flexibility needed for the Board to make commitments to financial assistance and to sell bonds to raise funds for those commitments before the end of each fiscal year. The Board funds the State Participation Account and Water Infrastructure Fund through the issuance of Water Financial Assistance Bonds, which are General Obligation Bonds of the State of Texas. Both the State Participation Account and Water Infrastructure Fund programs offer loans at discounts or with deferred interest, so they are non-self supporting programs, meaning that the Board is not able to pay the debt service on its Water Financial Assistance Bonds solely with the repayment of the loans it makes through these programs. Thus, the Texas Legislature appropriates funds to both of these programs as necessary to allow the Board to pay the debt service on its Bonds. The legislative appropriations are effective for each fiscal year starting September 1, so the Board attempts to sell bonds as necessary to fund existing commitments for financial assistance within each fiscal year, commensurate with the amount of Legislative appropriation for debt service for that fiscal year.

The proposed rulemaking also clarifies the Board's rule regarding the eligibility of reservoir projects for the Pre-design Funding Option under the Board's Water Infrastructure Fund.

SECTION BY SECTION DISCUSSION.

Section 363.1006. The proposed amendment of §363.1006(a) changes the application deadlines from January 1 and July 1 to February 1 and August 1 of each year. Applications for financial assistance are prioritized twice each year and are funded based on available funds. Current §363.1006(a) requires that applications for financial assistance from the State Participation Account and Water Infrastructure Fund, respectively, be submitted on January 1 and July 1 of each year for prioritization. However, the Board believes that revising these deadlines will provide better management of the sale of bonds in coordination with the Board's fiscal year. The Board needs to make commitments early enough during each fiscal year so that the Board may sell its bonds within that fiscal year to raise funds for those commitments, utilizing legislative appropriations available during each fiscal year. In addition, the January 1 deadline is difficult for applicants to meet because of holidays. Thus, the proposed rulemaking changes these application deadlines from January 1 and July 1 to February 1 and August 1 of each year, so that the Board can prioritize the applications in March and September, to allow adequate time to make commitments and sell bonds before the end of each fiscal year. In addition, the proposed rulemaking provides that the Executive Administrator may set additional application deadlines, prioritize applications, and present those applications to the Board for a commitment if the Executive Administrator deems it necessary in order to utilize available funds in any fiscal year.

The proposed amendment of §363.1006(a) also allows the Executive Administrator to accept abridged applications for prioritization purposes, as long as those applications contain adequate information to establish that the applicant qualifies for state participation funding, to describe the project comprehensively, and to establish the cost of the project, as well as any other information requested by the Executive Administrator. Section 363.1006(a) currently requires a complete application for prioritization purposes, and many applicants have found this requirement burdensome, especially when the applicant might not be ranked high enough to receive funding, depending on the availability of funds. Therefore, the proposed amendments allow the Executive Administrator to accept abridged applications for prioritization purposes, as long as those applications contain adequate information necessary for prioritization purposes.

The proposed amendment of §363.1006(a) also adds a provision that an applicant must submit a complete application to the board within 30 days after the board meeting at which the project receives priority for funding, or the project may lose its priority ranking and the board may commit to other projects consistent with the prioritization.

The proposed amendment of §363.1006(b) deletes the requirement that the Executive Administrator provide the Board a list of all completed applications, in order to be consistent with the proposed amendment of §363.1006(a) allowing the Executive Administrator to accept abridged applications for prioritization purposes. The amendment also adds language that clarifies that the Executive Administrator is to provide a prioritized list to the Board with applications recommended by the Executive Administrator.

The proposed amendment of §363.1006(c) deletes the requirement that legislatively-mandated projects receive priority for financial assistance and moves this requirement to §363.1007(a). Currently, §363.1006(c) contains the requirement that legislatively-mandated projects receive priority for financial assistance. However, the Executive Administrator should take this requirement into account when preparing the prioritized list under the prioritization criteria in §363.1007. Therefore, the proposed amendment moves this requirement to §363.1007 so that the Executive Administrator will prioritize the Legislatively-mandated projects first in the prioritized list that is presented to the Board under the procedures in §363.1006.

Section 363.1007. The proposed amendment of §363.1007 adds subsection (a) with the requirement that the board will give priority to projects that the Legislature has determined shall receive priority for financial assistance from the State Participation Account. It also renumbers current subsection (a) as (b), and requires that the Executive Administrator will prioritize projects after first prioritizing projects with legislative priority.

Section 363.1206. The proposed amendment of §363.1206(b) clarifies that reservoir projects are eligible for a Board commitment to fund planning, permitting, acquisition and design costs under the Water Infrastructure Fund pre-design funding option. Applicants for reservoir construction funds must complete planning, permitting, acquisition and design before receiving a commitment to fund reservoir building costs. The intent of the rule is to require applicants to obtain two separate commitments from the Board for reservoir pre-design activities versus construction activities, not to preclude the pre-design funding option for reservoirs altogether. Texas Water Code §15.974(a)(3) specifically provides for the funding of planning, design, and permitting costs from the Water Infrastructure Fund, which are considered pre-design activities. The amendment clarifies that, for reservoir projects, the Board intends to make commitments from the Water Infrastructure Fund for the building costs of reservoirs separately from the planning, permitting, acquisition, and design costs. The proposed amendment of §363.1206(b) is also consistent with the Board's proposed deletion of similar language prohibiting pre-design funding for reservoirs in §363.16(b), published in the December 12, 2008, edition of the *Texas Register* (33 TexReg 10133). That rulemaking will allow for the Board's commitment to fund all phases of a reservoir project under the pre-design funding option from the Board's financial assistance programs other than the Water Infrastructure Fund.

Section 363.1207. The proposed amendment of §363.1207(a) changes these application deadlines from January 1 and July 1 to February 1 and August 1 of each year. Applications for financial assistance are prioritized twice each year and are funded based on available funds. Current §363.1207(a) requires that applications for financial assistance from the State Participation Account and Water Infrastructure Fund, respectively, be submitted on January 1 and July 1 of each year for prioritization. However, the Board believes that revising these deadlines will provide better management of the sale of bonds in coordination with the Board's fiscal year. The Board needs to make commitments early enough during each fiscal year so that the Board may sell its bonds within that fiscal year to raise funds for those commitments, utilizing legislative appropriations available during each fiscal year. In addition, the January 1 deadline is difficult for applicants to meet because of holidays. Thus, the proposed rulemaking changes these application deadlines from January 1 and July 1 to February 1 and August 1 of each year, so that the Board can prioritize the applications in March and September, to allow adequate time to make commitments and sell bonds before the end of each fiscal year. In addition, the proposed rulemaking provides that the Executive Administrator may set additional application deadlines, prioritize applications, and present those applications to the Board for a commitment if the Executive Administrator deems it necessary in order to utilize available funds in any fiscal year.

The proposed amendment of §363.1207(a) also allows the Executive Administrator to accept abridged applications for prioritization purposes, as long as those applications contain adequate information to establish that the applicant qualifies for state participation funding, to describe the project comprehensively, and to establish the cost of the project, as well as any other information requested by the Executive Administrator. Section 363.1207(a) currently requires a complete application for prioritization purposes, and many applicants have found this requirement burdensome, especially when the applicant might not be ranked high enough to receive funding, depending on the availability of funds. Therefore, the proposed amendments allow the Executive Administrator to accept abridged applications for prioritization purposes, as long as those applications contain adequate information necessary for prioritization purposes.

The proposed amendment of §363.1207(a) also adds a provision that an applicant must submit a complete application to the board within 30 days after the board meeting at which the project receives priority for funding, or the project may lose its priority ranking and the board may commit to other projects consistent with the prioritization.

The proposed amendment of §363.1207(b) deletes the requirement that the Executive Administrator provide the board a list of all completed applications, in order to be consistent with the proposed amendment of §363.1207(a) allowing the Executive Administrator to accept abridged applications for prioritization purposes. The amendment also adds language that clarifies that the Executive Administrator is to provide a prioritized list to the Board with applications recommended by the Executive Administrator.

The proposed amendment of §363.1207(c) deletes the requirement that Legislatively-mandated projects receive priority for financial assistance and move the requirement to §363.1208(a). Currently, §363.1207(c) contains the requirement that legislatively-mandated projects receive priority for financial assistance. However, the Executive Administrator should take this requirement into account when preparing the prioritized list under the prioritization criteria in §363.1208. Therefore, the proposed amendment moves this requirement to §363.1208(a) so that the Executive Administrator will prioritize the Legislatively-mandated projects first in the prioritized list that is presented to the Board under the procedures in §363.1006.

Section 363.1208. The proposed amendment of §363.1208(a) adds the requirement that the board will give priority to projects that the Legislature has determined shall receive priority for financial assistance from the Water Infrastructure Fund.

The proposed amendment of §363.1208(c) adds the provision that the median annual household income may also be calculated using data from a survey approved by the Executive Administrator of a statistically acceptable sampling of customers in the service area completed within the last 12 months. Currently, §363.1208(c) requires the use of U.S. Bureau of the Census data. The amendment is necessary because certain areas of the State might not be able to determine the median annual household income from available U.S. Bureau of the Census data.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENTS

Melanie Callahan, Chief Financial Officer, has determined that there will be no fiscal implications for state or local governments as a result of the proposed rulemaking.

PUBLIC BENEFITS AND COSTS

Ms. Callahan also has determined that for each year of the first five years the proposed rulemaking is in effect, the public will benefit from the rulemaking because it will clarify and enhance the efficiency of the Board's operations and will impose no new requirements on the public or persons required to comply with the rules.

LOCAL EMPLOYMENT IMPACT STATEMENT

The Board has determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five

years that the proposed rules are in effect because it will impose no new requirements on local economies.

The Board has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing this rulemaking. The Board has also determined that there is no anticipated economic cost to persons who are required to comply with the rulemaking as proposed. Therefore, no regulatory flexibility analysis is necessary.

REGULATORY IMPACT ANALYSIS

The Board has determined that the proposed rulemaking is not subject to Government Code §2001.0225 because it is not a major environmental rule under that section.

TAKINGS IMPACT ASSESSMENT

The Board has determined that the promulgation and enforcement of these proposed rule amendments will constitute neither a statutory nor a constitutional taking of private real property. The proposed rule amendments do not adversely affect a landowner's rights in private real property, in whole or in part, temporarily or permanently, because these proposed rule amendments do not burden nor restrict or limit the owner's right to property. Therefore, the proposed amendments do not constitute a taking under Texas Government Code, Chapter 2007.

SUBMITTAL OF COMMENTS

Comments on the proposed rulemaking will be accepted for 30 days following publication and may be submitted to Legal Services, Texas Water Development Board, P.O. Box 13231, Austin, Texas78711-3231, rulescomments@twdb.state.tx.us, or by fax at (512) 463-5580.

SUBCHAPTER J. STATE PARTICIPATION PROGRAM

31 TAC §363.1006, §363.1007

STATUTORY AUTHORITY

This rulemaking is proposed under the authority of Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board; §15.977, which authorizes the board to adopt rules necessary to administer Texas Water Code, Chapter 15, Subchapter Q; and §15.995, which authorizes the board to adopt rules necessary to administer Texas Water Code, Chapter 15, Subchapter R.

Cross reference to statute: Texas Water Code, Chapters 15 and 17.

§363.1006. Prioritization System.

(a) The executive administrator will prioritize all applications not previously considered by the board twice annually [~~on February 1 and August 1 of each year~~]. An application must be submitted by February [~~January~~] 1 to be prioritized in March [~~on February 1~~]. An application must be submitted by August [~~July~~] 1 to be prioritized in September [~~on August 1~~]. The executive administrator will provide the prioritization to the board for approval in March and September [~~February and August~~] of each year or as soon thereafter as practicable. The executive administrator may set additional application deadlines, prioritize applications, and present the prioritization and those applications to the board for a commitment if the executive administrator deems it necessary in order to utilize available funds in any fiscal year. To be considered for prioritization, an applicant must provide adequate information to establish that the applicant qualifies for state participation funding, to describe the project comprehensively, and to establish the cost of the project, as well as any other information requested by the executive administrator. The executive administrator will develop and provide to applicants detailed information on the abridged application necessary for prioritization. If an applicant submits an abridged application for prioritization purposes, the applicant must submit a complete application to the board within 30 days after the board meeting at which the applicant's project received priority for funding, or the project may lose its priority ranking and the board may commit to other projects consistent with the prioritization.

(b) Prior to each board meeting at which applications may be considered, the executive administrator shall:

(1) for each application that the executive administrator has determined has adequate information for prioritization purposes [~~is complete~~], prioritize the applications using the criteria identified in §363.1007 of this title (relating to Prioritization Criteria).

(2) provide to the board a prioritized list of all [~~completed~~] applications as recommended by the executive administrator, the amount of funds requested and the priority of each application received; and

(3) identify to the board, the total amount of funds available in the State Participation Account for new applications.

(c) When making commitments for financial assistance from the State Participation Account, [~~If there are funds in the State Participation Account to fund all or part of any of the projects for which the executive administrator has received completed applications during the preceding six months,~~] the board will [~~first~~] consider [~~any~~] projects [~~that the legislature has determined shall receive priority for financial assistance from the State Participation Account. If, after considering projects with legislative priority, there are funds available for other eligible projects in the State Participation Account, then the board will consider such other applications received by the executive administrator during the preceding six month period~~] in descending numerical order based on the priority assigned to the application according to §363.1007 of this title. The board will consider the next application on the list only if there are funds available in the account to fund all or, if acceptable to the applicant, a part of the application.

(d) (No change.)

§363.1007. Prioritization Criteria.

(a) The board will give priority to projects that the legislature has determined shall receive priority for financial assistance from the State Participation Account.

(b) After first prioritizing projects that the legislature has determined shall receive priority, the [~~The~~] factors to be used by the executive administrator to prioritize the remaining projects seeking financial assistance from the State Participation Account shall be as follows:

(1) water development projects will receive priority over wastewater projects;

(2) priority will be given to projects which result in the development of a new, usable supply of water;

(3) priority will be given to projects which have received previous board funding for facility planning, design, or permitting for the project;

(4) priority will be given to entities that:

(A) have already demonstrated significant water conservation savings; or

(B) will achieve significant water conservation savings by implementing the proposed project for which the financial assistance is sought.

(5) priority will be given to projects which have the earliest identifiable need, as outlined in the water plan.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 16, 2009.

TRD-200900212
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 463-8061

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SUBCHAPTER L. WATER INFRASTRUCTURE FUND

31 TAC §§363.1206 - 363.1208

STATUTORY AUTHORITY

This rulemaking is proposed under the authority of Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board; §15.977, which authorizes the board to adopt rules necessary to administer Texas Water Code, Chapter 15, Subchapter Q; and §15.995, which authorizes the board to adopt rules necessary to administer Texas Water Code, Chapter 15, Subchapter R.

Cross reference to statute: Texas Water Code, Chapters 15 and 17.

§363.1206. Pre-design Funding Option.

(a) (No change.)

(b) Reservoir projects are eligible for a board commitment to fund planning, permitting, acquisition, and design costs [~~are not eligible for funding~~] under this option. Applicants for reservoir construction funds must complete planning, permitting, acquisition, and design before receiving a commitment to fund reservoir building costs.

(c) - (g) (No change.)

§363.1207. Prioritization System.

(a) The executive administrator will prioritize all applications not previously considered by the board twice annually [~~on February 1 and August 1 of each year~~]. An application must be submitted by February [~~January~~] 1 to be prioritized in March [~~on February 1~~]. An application must be submitted by August [~~July~~] 1 to be prioritized in September [~~on August 1~~]. The executive administrator will provide the prioritization to the board for approval in March and October [~~February and August~~] of each year or as soon thereafter as practicable. The executive administrator may set additional application deadlines, prioritize applications, and present the prioritization and those applications to the board for a commitment if the executive administrator deems it necessary in order to utilize available funds in any fiscal year. To be considered for prioritization, an applicant must provide adequate information to establish that the applicant qualifies for Water Infrastructure Fund funding, to describe the project comprehensively, and to establish the cost of the project, as well as any other information requested by the executive administrator. The executive administrator will develop and provide to applicants detailed information on the abridged application necessary for prioritization. If an applicant submits an abridged application for prioritization purposes, the applicant must submit a complete application to the board within 30 days after the board meeting at which the applicant's project received priority for funding, or the project may lose its priority ranking and the board may commit to other projects consistent with the prioritization.

(b) Prior to each board meeting at which applications may be considered for prioritization, the executive administrator shall:

(1) for each application that the executive administrator has determined has adequate information for prioritization purposes [~~is complete~~], prioritize the applications by the criteria identified in §363.1208 of this title (relating to Prioritization Criteria).

(2) provide to the board a prioritized list of all [~~completed~~] applications as recommended by the executive administrator, the amount of funds requested and the priority of each application received and

(3) identify [~~to the board,~~] the total amount of funds available in the Water Infrastructure Fund for new applications.

(c) If there are funds in the Water Infrastructure Fund available for all or part of any of the prioritized projects, [~~to fund all or part of any of the projects for which the executive administrator has received completed applications during the preceding six months,~~] the board will first consider any projects that the legislature has determined shall receive priority for financial assistance from the Water Infrastructure Fund. If, after considering projects with legislative priority, there are funds available for other eligible projects in the Water Infrastructure Fund, then the board will consider applications to make a commitment for financial assistance [~~such other applications received by the executive administrator during the preceding six month period~~] in descending order of priority according to §363.1208 of this title. The board will consider the next application on the list only if there are funds available in the account to fund all or, if acceptable to the applicant, a part of the application.

§363.1208. Prioritization Criteria.

(a) The board will give priority to projects that the legislature has determined shall receive priority for financial assistance from the Water Infrastructure Fund. Applicants who have applied and were eligible for Economically Distressed Areas Program funding under §363.512 of this title (relating to Projects Related to Implementation of the Water Plan), and where sufficient funds are not available in the program to fund the project, will be given priority [~~first~~] consideration for funding under this subchapter after projects with legislative priority.

(b) After prioritizing projects under subsection (a) of this section, the executive administrator will prioritize [~~Notwithstanding subsection (a) of this section,~~] applications [~~shall be prioritized~~] based on the number of factors met by the project seeking financial assistance. The following factors shall be considered by the executive administrator [~~Executive Administrator~~] when ranking the applications:

(1) projects which result in the development of a new, usable supply of water;

(2) projects which have the earliest identified need, as identified in the water plan; and

(3) entities that:

(A) have already demonstrated significant water conservation savings; or

(B) will achieve significant water conservation savings by implementing the proposed project for which the financial assistance is sought.

(c) If two or more projects receive the same priority ranking, priority will be given to the project having the service area with the lowest median annual household income, weighted by population of each of the areas served, based upon the most current data available from the U.S. Bureau of the Census for all the areas to be served by the project. The median annual household income may also be calculated using data from a survey approved by the executive administrator of a statistically acceptable sampling of customers in the service area completed within the last 12 months.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 16, 2009.

TRD-200900213
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 463-8061

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CHAPTER 371. DRINKING WATER STATE REVOLVING FUND

SUBCHAPTER I. PROVISIONS RELATING TO APPLICATIONS FOR FINANCIAL ASSISTANCE UNDER SPECIAL CAPITALIZATION GRANTS; EXPEDITED REVIEW, PROCESSING AND LOAN CLOSING REQUIREMENTS

31 TAC §§371.200 - 371.208

The Texas Water Development Board (board) proposes to add a new Subchapter I, §§371.200 - 371.208, to Chapter 371, relating to the Drinking Water State Revolving Fund, in order to provide for an expedited financial application review, processing and closing process for applications which have been filed in response to special federal capitalization grants for emergency events, economic recovery efforts and similar special initiatives. The purpose of these proposed rules is to provide the board with appropriate flexibility in complying with terms and conditions required for special funding in order to ensure that the funding is fully utilized to the benefit of the state's political subdivisions.

The board proposes new §371.200 (relating to Purpose) in order to make clear that the provisions of the Subchapter I are to be interpreted and applied in a manner that fully supports whatever flexibility is necessary and appropriate to implement the terms and conditions of any special capitalization grant.

The board proposes new §371.201 (relating to Definitions) to define the terms "capitalization grant", "emergency event" and "ready to proceed". The term "capitalization grant" means a capitalization grant funded by a special appropriation from the United States Congress for any special purpose, including, but not limited to, responding to emergency events and supporting economic recovery efforts. The term "emergency event" shall be broadly defined to include natural disasters such as hurricanes, tornadoes, flooding events, earthquakes, prolonged drought conditions and other natural disasters as well as man-made disasters, acts of terrorism or enemy attacks that result in damage to or the impairment of a public water supply system. The term "ready to proceed" means that a project has all of the approvals required in this chapter needed in order to commence construction.

The board proposes new §371.202 (relating to Eligibility Requirements) to define those projects and activities that are eligible for this expedited application review, processing and closing process. All projects must be listed on an intended use plan for the Drinking Water State Revolving Fund program and must further be related to or arising from an emergency event(s) or an economic recovery initiative or other special purpose being implemented by the EPA or other federal agency through a capitalization grant agreement executed by and between the board and the EPA.

The board proposes new §371.203 (relating to Intended Use Plan) to provide procedures to develop an IUP as necessary to implement any special capitalization grant. The intended use plan will identify those projects anticipated to receive assistance from funds available under the capitalization grant. The list of projects in the IUP, which shall be presented by priority ranking, may also serve as a project priority list if required by the capitalization grant.

The board proposes new §371.204 (relating to Applicable Rules) to provide that the rules governing applications for funding from the state's Drinking Water State Revolving Fund will be generally applicable to an application for expedited review, processing and closing under this subchapter, except as provided otherwise in this subchapter.

The board proposes new §371.205 (relating to Review of Applications by Executive Administrator) to explain the manner in which the staff intends to review and process the incoming applications seeking expedited review. The executive administrator shall review the application to determine whether it is administratively complete and shall request any additional information needed in order to process the application as soon as practicable. Such information shall be provided within the timeframe specified by the executive administrator. Once administratively and technically complete, the application will be scheduled for board consideration.

The board proposes new §371.206 (relating to Formal Action by the Board) to specify the manner in which applications undergoing expedited review and processing under this subchapter will be considered by the Board. The executive administrator shall present the application to the Board as soon as practicable after the application has been deemed administratively complete, the project has been deemed eligible for funding and the project has been deemed to be technically feasible. The applicant and other interested parties known to the board will be notified of the time and place of the board meeting prior to the meeting and arguments both for and against the issuance of the loan commitment may be made at that time.

At the conclusion of the meeting, the board will have the authority to approve, disapprove, amend or continue consideration of the application. The board may only approve the application if it finds that the revenue and/or taxes pledged by the applicant will be sufficient to meet all obligations assumed by the applicant. The

commitment will specify the applicable commitment period, after which time the commitment expires.

The board proposes new §371.207 (relating to Lending Rates) to define pertinent terms and to establish procedures that will be used to set lending rates for projects arising from emergency events, economic recovery efforts, or other special purposes consistent with the terms of the capitalization grant. In establishing the procedure to be used to set rates for applications processed under this subchapter, the executive administrator shall set interest rates for loans under this subchapter based upon costs of funds to the board, risk factors associated with managing the board's loan portfolio, market rate scales, and other factors consistent with the capitalization grant. In terms of timing, the executive administrator will set rates for loans on a date that is five (5) business days prior to the adoption of the political subdivision's bond ordinance or resolution or the execution of a loan agreement; and not more than 45 days before the anticipated closing of the loan from the board. After 45 days from the assignment of the interest rate on the loan, the rates may only be extended with the executive administrator's approval.

The board proposes a new §371.208 (relating to Waiver of Rules) to allow the provisions of this subchapter to be waived or modified by the executive administrator as necessary and appropriate to implement the terms of the capitalization grant or to comply with the conditions of the capitalization grant agreement. The board must find that all waivers or modifications of this subchapter are necessary and appropriate to implement the terms of the capitalization grant or to comply with the conditions of the capitalization grant agreement prior to approving an application for financial assistance using this expedited review, processing and closing process.

Mr. Gregory Kuchy, P.E., Deputy Executive Administrator, has determined that for the first five years the sections are in effect, there will be no significant fiscal implications for state or local governments as a result of implementing the amendment to this section.

Mr. Kuchy has determined that for the first five years the sections are in effect there are not expected to be any reductions in the cost to the state or to local governments as the result of administering the rule.

Mr. Kuchy has determined that during the first five years the sections are in effect that there is not expected to be any increase in or loss of revenue to the state or local governments as the result of administering the rule.

Mr. Kuchy has also determined that for each year of the first five years the sections are in effect, the public benefit will be better assurance that any special appropriation made available to the state will be fully utilized to the benefit of the state and its political subdivisions. Further, Mr. Kuchy has determined that there is no economic cost to the board or any effect on small business or micro-business. There is no anticipated economic cost to persons who are required to comply with the proposed section.

Comments on the proposal will be accepted for 30 days following publication and may be submitted to Michelle A. McFaddin, Staff Attorney, Legal Services, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, by e-mail to rulescomments@twdb.state.tx.us or by fax at (512) 463-5580.

Statutory authority: Water Code, §6.101 and §15.605.

Statute affected: Water Code, Chapter 15, Subchapter J.

Cross reference to statute: Water Code, Chapter 15, Subchapter J.

§371.200. Purpose.

It is the purpose of this subchapter to specify flexibility in providing financial assistance made available under a special capitalization grant as necessary and appropriate to the terms of that capitalization grant or the requirements of any capitalization grant agreement to the greatest extent necessary. The provisions of this subchapter should be interpreted and applied in order to fully utilize the funds made available for the benefit of the state and its political subdivisions.

§371.201. Definitions.

In addition to the definitions at §371.2 of this title (relating to Definition of Terms), the following terms, when used in this subchapter, shall have the following meanings:

(1) Capitalization grant--a capitalization grant funded by special appropriation by the United States Congress for any special purpose, including but not limited to responding to emergency events and supporting economic recovery.

(2) Emergency event--a natural disaster such as a hurricane, tornado, significant flooding event, prolonged drought or other natural disaster or a man-made disaster, an act of terrorism or an enemy attack that results in damage to or impairment of a public water supply system.

(3) Ready to proceed--a project has all of the approvals required in this chapter needed in order to commence construction.

§371.202. Eligibility Requirements.

(a) This subchapter shall apply to all applications for financial assistance filed by political subdivisions for projects that are listed in a Drinking Water State Revolving Fund intended use plan (IUP). The expedited process established in this subchapter is intended to streamline the processing of financial assistance applications filed for financing opportunities available under special capitalization grant(s) made available by the Environmental Protection Agency or other federal agencies to the board for purposes including, but not limited to, responding to emergency events or implementing federal economic recovery projects.

(b) In addition to other eligible projects, eligible projects may include the rehabilitation and/or replacement of or upgrades to water collection, distribution and treatment facilities, units and any appurtenant equipment.

(c) Specific eligibility requirements may be specified by the executive administrator consistent with the terms of the capitalization grant.

§371.203. Intended Use Plan.

(a) The board shall prepare an intended use plan (IUP) in cooperation with Texas Commission on Environmental Quality (TCEQ) to meet the requirements of the capitalization grant. The IUP will identify those projects anticipated to receive assistance from funds available under the capitalization grant. The list of projects in the IUP, which shall be presented by priority ranking, may also serve as a project priority list if required by the capitalization grant.

(b) The process for listing projects in the IUP shall be as follows.

(1) As necessary, the executive administrator will provide written notice and solicit project information from entities desiring to receive funding commitments. The notice shall include the form(s) to be used to submit information needed to rate the project and the

deadline by which such rating information must be submitted in order for project to be rated and included in the IUP. The required project information shall include, at a minimum, the following:

(A) the information needed to rate the project;

(B) a description of the proposed facilities;

(C) a description of any required permits, licenses, registrations and other legal authorizations;

(D) the estimated total project cost;

(E) an estimated schedule for construction of the proposed project;

(F) whether the applicant is under enforcement by the TCEQ or the EPA;

(G) for those potential applicants with existing populations of 25,000 or fewer, information regarding whether the community is eligible to receive funding as a disadvantaged community as defined in §371.24 of this title (relating to Disadvantaged Community Program through Loan Subsidies);

(H) a statement that the project is ready to proceed to construction with sufficient detail to support and justify the expedited review process; and

(I) such other information as may be requested by the executive administrator.

(2) The required information must be submitted not later than the deadline specified in the most recent written notice.

(c) Subsequent to adoption of an IUP, the nature of a proposed project included in the IUP may change with written approval of the executive administrator consistent with the terms of the capitalization grant:

(d) If any changes are proposed to the project which would result in a change to the rating score, the project must be re-ranked in the IUP. In this case, the availability of funds will be determined based on the revised rating score.

(e) The IUP will be presented for adoption to the board at a scheduled meeting at which time the board will receive public comment before adopting the plan.

(f) The executive director may revise the rating process established in §371.19 of this title (relating to Rating Process) for those applicants seeking an expedited review under this subchapter provided that this revised process is consistent with the capitalization grant and is approved by the board.

§371.204. Applicable Rules.

(a) An application shall comply with the requirements of this Chapter 371, Subchapters A - H, except as otherwise provided in Subchapter I or specified by the executive administrator.

(b) In addition to requirements for applications incorporated under subsection (a) of this section, an application under this subchapter shall include a brief description of the project including, but not limited to, the following:

(1) the need for the project;

(2) that the project is consistent with the purposes of the capitalization grant, as defined by terms of the capitalization grant agreement and as determined by the board;

(3) that the project is ready to proceed to construction with sufficient detail to support and justify the expedited review process;

(4) that the applicant will comply with Disadvantaged Business Enterprise "fair share" goals in procuring the project contractors and subcontractors unless expressly waived by the terms of the capitalization grant;

(5) that applications have been filed and/or granted for all applicable local, state and federal permitting, licensing and registration permits, licenses, registrations and other legal authorizations required for the construction and operation of the project; and

(6) that provides the status of any environmental review activities performed in accordance with or in response to the environmental review requirements set forth in §371.35 of this title (relating to Required Environmental Review and Determinations).

§371.205. Expedited Review of Applications by the Executive Administrator.

The executive administrator will commence a review for administrative completeness as soon as practicable upon receipt of the application and may request any modifications or additional information to ensure consistency with the requirements of this subchapter and the terms of the capitalization grant. The applicant shall respond to any request for modification or for additional information within the timeframe specified in the executive administrator's request. Once the application has been deemed to be administratively complete, the executive administrator will commence an technical review of the project to ensure that it is eligible for processing under this subchapter and that the project is feasible. When this technical review is complete, the application shall be scheduled for board consideration.

§371.206. Formal Action by the Board.

(a) Presentation to board. The executive administrator shall present the application to the board after completing a review of the application. The applicant and other interested parties known to the board shall be notified of the time and place of such meeting. Evidence and arguments both for and against the granting of the application may be heard at such meeting.

(b) Action by board. At the conclusion of the meeting to consider the project, the board may resolve to approve, disapprove, amend, or continue consideration of the application. The board shall approve an application only if the board finds that in its opinion the revenue or taxes or both revenue and taxes pledged by the applicant will be sufficient to meet all obligations assumed by the applicant and the assistance requested meets the requirements of the federal act and state law.

(c) Commitment period. Loan approval action will specify the commitment period consistent with the terms of the capitalization grant, after which time the commitment shall expire.

§371.207. Lending Rates.

(a) Procedure for setting interest rates.

(1) The executive administrator shall establish a procedure to set a lending rate for projects that is consistent with the terms of the capitalization grant, to be considered by the board in approving the application.

(2) In establishing the procedure for setting interest rates, the executive administrator may consider factors that include, but are not necessarily limited to:

(A) the market rate for the borrower;

(B) the amount of adjustment from the market interest rate appropriate for the borrower;

(C) the identified interest rate adjustment to the market rate for the borrower needed to determine the loan interest rate, and;

(D) may apply the loan interest rate to the proposed principal schedule.

(3) The executive administrator will set rates for loans on a date that is:

(A) five business days prior to the adoption of the political subdivision's bond ordinance or resolution or the execution of a loan agreement; and

(B) not more than 45 days before the anticipated closing of the loan from the board.

(4) After 45 days from the assignment of the interest rate on the loan, rates may be extended only with the executive administrator's approval.

(b) The board, based on the procedure established by the executive administrator under subsection (a) of this section, will set interest rates for loans under this subchapter based upon costs of funds to the board, risk factors associated with managing the board's loan portfolio, market rate scales, and other factors consistent with the capitalization grant.

§371.208. Waiver of Rules.

(a) Any of the provisions of this subchapter may be waived or modified by the executive administrator as necessary and appropriate to implement the terms of the capitalization grant or to comply with the requirements of the capitalization grant agreement.

(b) The board must find that all waivers or modifications of this subchapter are necessary and appropriate to implement the terms of the capitalization grant or to comply with the requirements of the capitalization grant agreement prior to approving an application for financial assistance.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

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Kenneth L. Petersen
General Counsel
Texas Water Development Board
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 463-8061

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CHAPTER 375. CLEAN WATER STATE REVOLVING FUND

The Texas Water Development Board (board) proposes an amendment to §375.2 and new §§375.400 - 375.408. The board proposes to add a new Subchapter D, §§375.400 - 375.408, to 31 Texas Administrative Code (TAC) Chapter 375, relating to Clean Water State Revolving Fund, in order to provide for an expedited financial application review, processing and closing process for applications which have been filed in response to special federal capitalization grants for emergency events, economic recovery efforts and similar special initiatives. The purpose of these proposed rules is to provide the board with appropriate flexibility in complying with terms and conditions required for special funding in order to ensure that the funding is fully utilized to the benefit of the state's political subdivisions.

Specifically, the board proposes to amend 31 TAC §375.2(17) relating to the term "construction" to more closely track the definition of "construction" found in §212(1) of the Federal Water Pollution Control Act, as amended. In addition to benefitting the administration of the traditional Clean Water State Revolving Fund by expanding the scope of eligible projects, the amended definitions will expand the scope of projects eligible for special capitalization grant funding.

The board proposes to amend 31 TAC §375.2(67) relating to the term "treatment works" to more closely track the definition of "treatment works" found in §212(2)(A) and (B) of the Federal Water Pollution Control Act, as amended, as incorporated by §15.602, Water Code. The proposed revisions to the board's definition of "treatment works" will explicitly allow funding for the preventing, abating, reducing, storing, treating, separating, or disposing of storm water runoff and waste combined in storm water and sanitary sewer systems, the type of projects that often arise in response to emergency events.

The board also proposes to add a new Subchapter D, §§375.400 - §375.408, in order to provide an expedited financial application review, processing and closing process for those applications for financial assistance that have been filed in response to emergency events, economic recovery efforts and similar special initiatives for which the board has received a capitalization grant.

The board proposes new §375.400 (relating to Purpose) in order to make clear that the provisions of subchapter D are to be interpreted and applied in a manner that fully supports whatever flexibility is necessary and appropriate to implement the terms and conditions of any special capitalization grant.

The board proposes new §375.401 (relating to Definitions) to define the terms "capitalization grant", "emergency event" and "ready to proceed". The term "capitalization grant" means a capitalization grant funded by special appropriation by the United States Congress for any special purpose, including, but not limited to, responding to emergency events and supporting economic recovery initiatives. The term "emergency event" shall be broadly defined to include natural disasters such as hurricanes, tornadoes, flooding events, prolonged drought conditions, earthquakes and other natural disasters as well as man-made disasters, acts of terrorism or enemy attacks that result in damage to or the impairment of publicly-owned wastewater collection, distribution and treatment works. The term "ready to proceed" means that a project has all of the approvals required in this chapter needed in order to commence construction.

The board proposes new §375.402 (relating to Eligibility Requirements) to define those projects and activities that are eligible for this expedited application review, processing and closing process. All projects must be listed on an intended use plan for the Clean Water State Revolving Fund program and must further be related to or arising from an emergency event(s) or an economic recovery initiative or other special purpose being implemented by the EPA or other federal agency through a capitalization grant agreement executed by and between the board and the federal agency. Activities which are eligible for funding are broadly defined as any activities, including but not necessarily limited to, collection and distribution system upgrades, equipment upgrades and replacements, treatment system rehabilitation and improvements and other related activities that will address damage to or impairment of wastewater collection, distribution and treatment facilities.

The board proposes new §375.403 (relating to Intended Use Plan) to provide procedures to develop an IUP as necessary to implement any special capitalization grant. The intended use plan will identify those projects anticipated to receive assistance from funds available under the capitalization grant. The list of projects in the IUP, which shall be presented by priority ranking, may also serve as a project priority list if required by the capitalization grant.

The board proposes new §375.404 (relating to Applicable Rules) to provide that the rules governing applications for funding from the state's Drinking Water State Revolving Fund will be generally applicable to an application for expedited review, processing and closing under this subchapter, except as provided otherwise in this subchapter.

The board proposes new §375.405 (relating to Review of Applications by Executive Administrator) to explain the manner in which the staff intends to review and process the incoming applications seeking expedited review. The executive administrator shall review the application to determine whether it is administratively complete and shall request any additional information needed in order to process the application as soon as practicable. Such information shall be provided within the timeframe specified by the executive administrator. Once administratively and technically complete, the application will be scheduled for Board consideration.

The board proposes new §375.406 (relating to Formal Action by the Board) to specify the manner in which applications undergoing expedited review and processing under this subchapter will be considered by the Board. The executive administrator shall present the application to the Board as soon as practicable after the application has been deemed administratively complete, the project has been deemed eligible for funding and the project has been deemed to be technically feasible. The applicant and other interested parties known to the board will be notified of the time and place of the board meeting prior to the meeting and arguments both for and against the issuance of the loan commitment may be made at that time.

At the conclusion of the meeting, the board will have the authority to approve, disapprove, amend or continue consideration of the application. The board may only approve the application if it finds that the revenue and/or taxes pledged by the applicant will be sufficient to meet all obligations assumed by the applicant. The commitment will specify the applicable commitment period, after which time the commitment expires.

The board proposes new §375.407 (relating to Lending Rates) to define pertinent terms and to establish the procedures that will be used to set lending rates for projects arising from emergency events, economic recovery efforts, or other special purpose consistent with the terms of the capitalization grant. In establishing the procedure to be used to set rates for applications processed under this subchapter, the executive administrator shall consider factors that include, but are not necessarily limited to, the appropriate market rate for the borrower, the amount of adjustment from the market interest rate that may be appropriate for the borrower, any interest rate adjustment to the market rate for the borrower that may be required in order to determine the loan interest rate, and the manner in which that loan interest rate should be applied to the proposed principal schedule. In terms of timing, the executive administrator will set rates for loans on a date that is five (5) business days prior to the adoption of the political subdivision's bond ordinance or resolution or the execution of a loan agreement; and not more than 45 days before the anticipated closing of the loan from the board. After 45 days from the assignment of the interest rate on the loan, the rates may only be extended with the executive administrator's approval.

Finally, the board proposes a new §375.408 (relating to Waiver of Rules) to allow the provisions of this chapter to be waived or modified by the executive administrator as necessary and appropriate to implement the terms of the capitalization grant or to comply with the conditions of the capitalization grant agreement. The board must find that all waivers or modifications of this subchapter are necessary and appropriate to implement the terms of the capitalization grant or to comply with the conditions of the capitalization grant agreement prior to approving an application for financial assistance using this expedited review, processing and closing process.

Mr. Gregory Kuchy, P.E., Deputy Executive Administrator, has determined that for the first five-year period the amendments are in effect, there will be no fiscal implications on state and local government as a result of the implementation of the amended sections.

Mr. Kuchy has also determined that for each year of the first five years the section is in effect, the public benefit will be better assurance that any special appropriation made available to the state will be fully utilized to the benefit of the state and its political subdivisions. Further, Mr. Kuchy has determined that there is no economic cost to the board or any effect on small business. There is no anticipated economic cost to persons who are required to comply with the proposed section.

Comments on the proposal will be accepted for 30 days following publication and may be submitted to Michelle A. McFaddin, Staff Attorney, Legal Services, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, by e-mail to rulescomments@twdb.state.tx.us or by fax at (512) 463-5580.

SUBCHAPTER A. GENERAL PROVISIONS

31 TAC §375.2

Statutory authority: Water Code, §6.101 and §15.605.

Statute affected: Water Code, Chapter 15, Subchapter J.

Cross reference to statute: Water Code, Chapter 15, Subchapter J.

§375.2. Definitions of Terms.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Words defined in the Texas Water Code, Chapter 15 and not defined here shall have the meanings provided by the chapter or subchapter as appropriate.

(1) - (16) (No change.)

(17) Construction--Any one or more of the following:

(A) preliminary planning to determine the feasibility of treatment works [~~a project~~];

(B) engineering, architectural, environmental, legal, title, fiscal, or economic investigations or studies;

[~~(C) the expense of any condemnation or other legal proceeding;~~]

(C) [~~(D)~~] surveys, designs, plans, working drawings, specifications, procedures, field testing of innovative or alternative

waste water treatment processes and techniques pursuant to section 1314(d)(3) of the Act; and

(D) other necessary actions, erection, building, acquisition, alternation, remodeling, improvement, or extension of treatment works, or the inspection or supervision of any of the foregoing items.

[~~(E) the building of a project or the inspection or supervision of any of the foregoing items.~~]

(18) - (66) (No change.)

(67) Treatment works--Any devices and systems which are used in the storage, treatment, recycling, and reclamation of waste or which are necessary to recycle or reuse water at the most economical cost over the estimated life of the works, including intercepting sewers, outfall sewers, sewage collection systems, pumping, power, and other equipment and their appurtenances; extensions, improvements, remodeling, additions, and alterations thereof; elements essential to provide a reliable recycled supply such as standby treatment units and clear well facilities; and any works, including site acquisition of the land that will be an integral part of, or used in connection with, the treatment process (including land used for the storage of treated water in land treatment systems prior to land application) or is used for ultimate disposal of residues resulting from such treatment; or facilities to provide for the collection, control, and disposal of waste. The term also means any other method or system for preventing, abating, reducing, storing, treating, separating, or disposing of municipal waste, including storm water runoff; and waste combined in storm water and sanitary sewer systems, the type of projects that often arise in response to emergency events.

(68) - (72) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Kenneth L. Petersen
General Counsel
Texas Water Development Board
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For further information, please call: (512) 463-8061

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SUBCHAPTER D. PROVISIONS RELATING TO APPLICATIONS FOR FINANCIAL ASSISTANCE FILED IN RESPONSE TO SPECIAL CAPITALIZATION GRANTS; EXPEDITED REVIEW, PROCESSING AND LOAN CLOSING REQUIREMENTS

31 TAC §§375.400 - 375.408

Statutory authority: Water Code, §6.101 and §15.605.

Statute affected: Water Code, Chapter 15, Subchapter J.

Cross reference to statute: Water Code, Chapter 15, Subchapter J.

§375.400. Purpose.

It is the purpose of this subchapter to specify flexibility in providing financial assistance made available under a special capitalization grant as necessary and appropriate to the terms of that capitalization grant or the requirements of any capitalization grant agreement to the greatest extent necessary. The provisions of this subchapter should be interpreted and applied in order to fully utilize the funds made available for the benefit of the state and its political subdivisions.

§375.401. Definitions.

In addition to the definitions at §375.2 of this chapter (relating to Definitions of Terms), the following terms, when used in this subchapter, shall have the following meanings:

(1) Capitalization grant--A capitalization grant funded by special appropriation enacted by the United States Congress for any special purpose, including, but not limited to, to respond to emergency events or to implement an economic recovery program.

(2) Emergency event--A natural disaster such as a hurricane, tornado, significant flooding event, prolonged drought, earthquake or other natural disaster or man-made disaster such as an act of terrorism or an enemy attack that results in damage to or impairment of a publicly-owned wastewater collection, distribution and treatment system.

(3) Ready to proceed--A project that has all of the approvals required in this chapter needed in order to commence construction.

§375.402. Eligibility Requirements.

(a) This subchapter shall apply to all applications for financial assistance filed by political subdivisions for projects that are listed in a Clean Water State Revolving Fund intended use plan (IUP). The expedited process established in this subchapter is intended to streamline the processing of financial assistance applications filed for financing opportunities available under special capitalization grant(s) made available by the EPA or other federal agencies to the board for purposes including, but not limited to, responding to emergency events or implementing federal economic recovery projects.

(b) In addition to other eligible projects, eligible projects may include the rehabilitation and/or replacement of or upgrades to wastewater collection, distribution and treatment facilities, units and any appurtenant equipment.

(c) Specific eligibility requirements may be specified by the executive administrator consistent with the terms of the capitalization grant.

§375.403. Intended Use Plan.

(a) The board shall prepare an intended use plan to meet the requirements of the capitalization grant. The intended use plan (IUP) will identify those projects anticipated to receive assistance from funds available under the capitalization grant. The list of projects in the IUP, which shall be presented by priority ranking, may also serve as a project priority list if required by the capitalization grant.

(b) The process for listing projects in the intended use plan shall be as follows.

(1) As necessary, the executive administrator will provide written notice and solicit project information from entities desiring to receive funding commitments. The notice shall include the form(s) to be used to submit information needed to rate the project and the deadline by which such rating information must be submitted in order for project to be rated and included in the intended use plan. The required project information shall include, at a minimum, the following:

(A) the information needed to rate the project;

(B) a description of the proposed facilities;

(C) a description of any required permits, licenses, registrations and other legal authorizations, including any projected effluent limitations that may be required in any permit or registration issued by the Texas Commission on Environmental Quality (TCEQ) or the EPA;

(D) the estimated total project cost;

(E) an estimated schedule for construction of the proposed project;

(F) whether the applicant is under enforcement by the TCEQ or the EPA;

(G) for those potential applicants with existing populations of 25,000 or fewer, information regarding whether the community is eligible to receive funding as a disadvantaged community as defined in §375.19 of this chapter (relating to Financial assistance for projects benefiting disadvantaged communities); and

(H) such other information as may be requested by the executive administrator.

(2) The required information must be submitted not later than the deadline specified in the written notice.

(c) Subsequent to adoption of an intended use plan, the nature of a proposed project included in the intended use plan may change with written approval of the executive administrator consistent with the terms of the capitalization grant.

(d) If any changes are proposed to the project which would result in a change to the rating score, the project must be re-ranked in the intended use plan. In this case, the availability of funds will be determined based on the revised rating score.

(e) The intended use plan will be presented for adoption to the board at a scheduled meeting at which time the board will receive public comment before adopting the plan. Notice of this meeting shall be afforded to the public, the applicant and other known, interested parties prior to the Board meeting at which the intended use plan will be considered for adoption.

(f) The executive director may revise the rating process established in §375.16 of this chapter (relating to Rating Process) for those applicants seeking an expedited review under this subchapter provided that this revised process is consistent with the capitalization grant and is approved by the board.

§375.404. Applicable Rules.

(a) An application shall comply with the requirements of Chapter 375, Subchapters A, B and C, except as otherwise provided in this subchapter or specified by the executive administrator.

(b) In addition to requirements for applications incorporated under subsection (a) of this section, an application under this subchapter shall include a brief description of the project including, but not limited to, the following:

(1) the need for the project;

(2) that the project is consistent with the purposes of the capitalization grant, as defined by terms of the capitalization grant agreement and as determined by the board;

(3) that the project is ready to proceed to construction with sufficient detail to support and justify the expedited review process;

(4) that the applicant will comply with Disadvantaged Business Enterprise "fair share" goals in procuring the project contractors and subcontractors unless expressly waived by the terms of the capitalization grant;

(5) that applications have been filed and/or granted for all applicable local, state and federal permitting, licensing and registration permits, licenses, registrations and other legal authorizations required for the construction and operation of the project; and

(6) that provides the status of any environmental review activities performed in accordance with or in response to the environmental review requirements set forth in §375.35 of this chapter (relating to Required Environmental Review and Determination).

§375.405. Review of Applications by the Executive Administrator.

The executive administrator will commence review for administrative completeness as soon as practicable upon receipt of the application and may request any modifications or additional information to ensure consistency with the following: Subchapters A, B and C of this chapter as well as §375.404 of this subchapter (relating to Applicable Rules). The applicant shall respond to any request for modification or for additional information within the timeframe specified in the executive administrator's request. Once the application has been deemed to be administratively complete, the executive administrator will commence a technical review of the project to ensure that it is eligible for processing under this subchapter and that the project is feasible. When this technical review is complete, the application shall be scheduled for board consideration.

§375.406. Formal Action by the Board.

(a) Presentation to board. The executive administrator shall present the application to the board after completing a review of the application. The applicant and other interested parties known to the board shall be notified of the time and place of such meeting. Evidence and arguments both for and against the granting of the application may be heard at such meeting.

(b) Action by board. At the conclusion of the meeting to consider the project, the board may resolve to approve, disapprove, amend, or continue consideration of the application. The board shall approve an application only if the board finds that in its opinion the revenue or taxes or both revenue and taxes pledged by the applicant will be sufficient to meet all obligations assumed by the applicant.

(c) Commitment period. Loan approval action will specify the commitment period consistent with the terms of the capitalization grant, after which time the commitment shall expire.

§375.407. Lending Rates.

(a) Procedure for setting interest rates.

(1) The executive administrator shall establish a procedure to set a lending rate for projects that is consistent with the terms of the capitalization grant, to be considered by the board in approving the application.

(2) In establishing the procedure for setting interest rates, the executive administrator may consider factors that include, but are not necessarily limited to, the market rate for the borrower, the amount of adjustment from the market interest rate appropriate for the borrower, the identified interest rate adjustment to the market rate for the borrower needed to determine the loan interest rate, and may apply the loan interest rate to the proposed principal schedule.

(3) The executive administrator will set rates for loans on a date that is:

(A) five business days prior to the adoption of the political subdivision's bond ordinance or resolution or the execution of a loan agreement; and

(B) not more than 45 days before the anticipated closing of the loan from the board.

(4) After 45 days from the assignment of the interest rate on the loan, rates may be extended only with the executive administrator's approval.

(b) The board, based on the procedure established by the executive administrator under subsection (a) of this section, will set interest rates for loans under this subchapter based upon costs of funds to the board, risk factors associated with managing the board's loan portfolio, market rate scales, and other factors consistent with the capitalization grant.

§375.408. Waiver of rules.

(a) Any of the provisions of this subchapter may be waived or modified by the executive administrator as necessary and appropriate to implement the terms of the capitalization grant or to comply with the requirements of the capitalization grant agreement.

(b) The board must find that all waivers or modifications of this subchapter are necessary and appropriate to implement the terms of the capitalization grant or to comply with the requirements of the capitalization grant agreement prior to approving an application for financial assistance.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900203
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 463-8061

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TITLE 34. PUBLIC FINANCE

PART 11. OFFICE OF THE FIRE FIGHTERS' PENSION COMMISSIONER

CHAPTER 302. GENERAL PROVISIONS RELATING TO THE TEXAS EMERGENCY SERVICES RETIREMENT SYSTEM

34 TAC §302.2

The State Board of Trustees of the Texas Emergency Services Retirement System (System) proposes amendments to §302.2, regarding minimum and maximum benefit distributions.

The amended rule would provide that benefit distributions from the System must comply with specific requirements of the federal Internal Revenue Code of 1986 and related regulations of the U.S. Department of the Treasury.

Lisa Ivie Miller, Commissioner, has determined that the public benefit for the first five years that the amended rule is in effect will be to ensure that the System remains tax-exempt under federal Internal Revenue Service requirements.

There would be no cost to local governments as a result of adoption of the proposed amended rule. The state would retain the ability to reap considerable savings by maintaining the System as a tax-exempt plan under federal law.

Small businesses or individuals would not be affected by the adoption of the proposed amended rule.

Comments on the proposed amended rule may be submitted in writing to Lisa Ivie Miller, Commissioner, Office of the Fire Fighters' Pension Commissioner, P.O. Box 12577, Austin, Texas 78711-2577, not later than February 27, 2009. Comments may also be submitted electronically to rules@ffpc.state.tx.us or faxed to (512) 936-3480.

The amended rule is proposed under the statutory authority of Title 8, Texas Government Code, Subtitle H, Texas Emergency Services Retirement System, §861.006.

No other statutes, articles, or codes are affected by the proposed amended rule.

§302.2. Benefit Distributions.

(a) In this section:

(1) "Code" means the Internal Revenue Code of 1986, as amended.

(2) "Section 401(a)(9) requirements" means the requirements under §401(a)(9) of the code and Treasury Regulations §§1.401(a)(9)-1 through 1.401(a)(9)-9.

(b) [~~(a)~~] The annual benefit based on the service of a member may not exceed the amount permitted by the code [~~Internal Revenue Code of 1986~~] and related regulations for the appropriate year, including, without limitation, §415(b) of the code. If the aggregated benefit otherwise payable under the pension system and any other defined benefit plan maintained by a political subdivision that has contributed to the fund on behalf of the member would otherwise exceed the benefits allowable under federal law, the reduction in benefits must first be applied to the extent possible from the other plan, and only after those reductions, from the fund.

(c) [~~(b)~~] A retirement annuity or benefits to a qualified beneficiary under the pension system may not begin after the deadlines provided under the code [~~Internal Revenue Code of 1986~~] and related regulations, including, without limitation, the deadlines provided by subsection (d) of this section.

(d) All distributions under the fund must at all times comply with and conform to the §401(a)(9) requirements, and any distribution required under the incidental death benefits requirements of §401(a) of the code will be treated as a distribution under the §401(a)(9) requirements. This subsection overrides any distribution options inconsistent with the §401(a)(9) requirements. The pension system shall develop procedures to ensure that distributions comply with the §401(a)(9) requirements, including the requirement that a member's entire interest under the system will be distributed, or begin to be distributed, to the member no later than April 1 of the year after the later of the year in which the member ceases performing qualified service for a participating department or the year in which the member attains age 70-1/2.

(e) If the annual compensation of a member is ever taken into account for any purpose of the fund, that annual compensation may not exceed the limit in effect under §401(a)(17) of the code, as periodically adjusted in accordance with guidelines provided by the United States Secretary of the Treasury.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900199
Craig Hudgins
General Counsel
Office of the Fire Fighters' Pension Commissioner
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 463-9935

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE PROBATION COMMISSION

CHAPTER 341. TEXAS JUVENILE PROBATION COMMISSION STANDARDS

SUBCHAPTER I. ELECTRONIC DATA INTERCHANGE SPECIFICATIONS

37 TAC §341.60

The Texas Juvenile Probation Commission proposes an amendment to §341.60 concerning the Commission's electronic data interchange specifications. The amendments are being proposed in an effort to reflect the accurate placement and services types that are currently available for juveniles.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the amendments are in effect, there will be no fiscal implications for state or local government. There will be no fiscal implications for small businesses or individuals as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the amendments are in effect, the public benefit expected as a result of enforcement or implementation will be to allow the public with more complete and detailed data which can be analyzed to better review juvenile justice trends, the provision of services and the needs of juveniles served by the system.

Public comments on the proposed amendments may be submitted to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547.

The amendment is proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other statute, article, or code will be affected.

§341.60. TJPC Monthly Folder Extract.

The TJPC Monthly Folder Extract data shall include all data fields required by TJPC Electronic Data Interchange Specifications found in the figure below.
Figure 1: 37 TAC §341.60 (No change.)

Figure 2: 37 TAC §341.60

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900113
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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CHAPTER 343. STANDARDS FOR SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES

The Texas Juvenile Probation Commission proposes the repeal of Chapter 343, §§343.1 - 343.17, 343.30 - 343.37, 343.45 - 343.52, and 343.60 - 343.68, relating to standards for secure juvenile pre-adjudication detention and post-adjudication correctional facilities. The repeal is in an effort to provide structural and substantive changes from the current standards.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state or local government. There will be no fiscal implications for small businesses or individuals as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide Texas Juvenile Probation Commission with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547.

SUBCHAPTER A. DEFINITIONS

37 TAC §343.1

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

This repeal is proposed under §141.042 of the Texas Human Resource Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.1. Definitions.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900134
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.2 - 343.17

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

This repeal is proposed under §141.042 of the Texas Human Resource Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.2. Administration and Management.
§343.3. Treatment and Safety.
§343.4. Data Collection.
§343.5. Physical Plant.
§343.6. Security and Control.
§343.7. Rules and Discipline.
§343.8. Food.
§343.9. Hygiene.
§343.10. Health Care Services.
§343.11. Communications.
§343.12. Residents' Rights.
§343.13. Volunteers and Interns.
§343.14. Waivers and Variances.
§343.15. Employment of Certified Juvenile Detention Officers.
§343.16. Persons Who Must be Certified.
§343.17. Code of Ethics.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200900135
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER C. PRE-ADJUDICATION SECURE DETENTION FACILITY STANDARDS

37 TAC §§343.30 - 343.37

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

This repeal is proposed under §141.042 of the Texas Human Resource Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.30. Intake, Admission and Release.
§343.31. Classification Plan.
§343.32. Supervision.
§343.33. Records.
§343.34. Sleeping Units.
§343.35. Multiple Occupancy Sleeping Units.
§343.36. Physical Plant.
§343.37. Programs.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER D. POST-ADJUDICATION SECURE CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.45 - 343.52

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

This repeal is proposed under §141.042 of the Texas Human Resource Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.45. Intake, Admission and Release.
§343.46. Classification Plan.
§343.47. Supervision.
§343.48. Records.
§343.49. Sleeping Units.

§343.50. Physical Plant.

§343.51. Rules and Discipline.

§343.52. Programs.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.60 - 343.68

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

This repeal is proposed under §141.042 of the Texas Human Resource Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.60. Definitions.

§343.61. Requirements.

§343.62. Prohibitions.

§343.63. Documentation.

§343.64. Physical Restraint.

§343.65. Mechanical Restraint.

§343.66. Restraint Chair.

§343.67. Chemical Agents.

§343.68. Transporting Residents Outside Facility.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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CHAPTER 343. SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES

The Texas Juvenile Probation Commission proposes new Chapter 343, §§343.100, 343.102, 343.104, 343.106, 343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268, 343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.344, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, 343.386, 343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432, 343.434, 343.436, 343.438, 343.440, 343.442, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, 343.498, 343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, 343.712, 343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, and 343.818, relating to standards for secure juvenile pre-adjudication detention and post-adjudication correctional facilities. These new standards are being proposed in an effort to ensure that the minimum standards for secure pre and post-adjudication juvenile facilities reflect practices specific to federal constitutional requirements, relevant federal statutes, and national standards and related best practices models. Additionally, these standards are being proposed to ensure that the Texas Juvenile Probation Commission's related standards monitoring expectations are clearly identified within the context of Administrative Code Rules.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the amendments are in effect, there will be no fiscal implications for small business as a result of enforcement or implementation. Ms. Capers has determined that there will be limited fiscal implications for state government and local government as a result of enforcement or implementation, including:

Section 343.404. Under this proposed standard, a consultation may result in fiscal implications if assessments or evaluations are recommended by a qualified mental health professional (QMHP) or a mental health professional (MHP). The diversity of the recommendations a QMHP or a MHP may make does not readily

lend itself to a reliable cost analysis. There could be a fiscal impact for those jurisdictions that do not have access to a QMHP or that do not employ a MHP. The costs associated with mental health consultations may be offset by the TJPC's $5 million Legislative Appropriations Request (LAR) to assist in funding mental health professionals in all pre and post-adjudication facilities across the state.

Section 343.406. This proposed standard would require professionally administered health assessments for detainees who are identified (by formalized screening, request, or observation) as having a medical need. Additionally, the standard would require a professionally administered health assessment for youth held in detention for 30 consecutive days that have not already had said assessment completed. The 30-day requirement would only impact a small percentage of the State's annual detention population because the current average length of stay is approximately 13 days. In 2007, approximately 6,300 (11.12%) of the 56,000 plus youth detained were held for 30 days or longer. Of these 6,300 youth, approximately 2,600 were detained in the State's three largest jurisdictions, which had health care professionals actually administering initial screenings or providing standardized follow up (i.e., assessment) of youth soon after admission (both practices would negate the need for 30-day assessments). The remaining 3,700 youth would be further reduced by exempting those with a prior health assessment (up to one year old) provided by an alternative source (e.g., school, parent, prior juvenile justice contact, etc.). The remaining detainees impacted by the proposed standards could be professionally assessed by a licensed nurse for approximately $85.00 per assessment.

Section 343.428 and §343.622. These proposed standards would require that before a juvenile supervision officer (i.e., juvenile detention officer) assumed their standardized supervision duties, an officer would have to complete training in at least 40 hours of designated core topics plus an additional 24 hours of training in restraint technique and basic first aid and CPR. This provision would require at least 64 hours of training before an officer assumed his or her duties. Currently, an officer can assume these duties with approximately 28 to 32 hours of instruction in a restraint technique (approximately 16 hours), first aid and CPR (8 hours combined), abuse and neglect reporting requirements (2-4 hours), and facility-specific resident suicide prevention policies (2-4 hours). Therefore, the required training hours (and potential associated costs) could increase by approximately 44%. The TJPC has increased the availability of web-based training seminars to help offset increased training requirements.

Section 343.812. There are multiple provisions within this proposed standard that may have a fiscal impact on those select secure facilities that utilize non-ambulatory restraints. It is important to note that use of non-ambulatory restraint devices is not required per TJPC standards. Therefore, the following fiscal impact summaries would be applicable only to those jurisdictions that decide to incorporate non-ambulatory restraints. Subsection (d) of this section would restrict resident rooms with fixed restraint apparatus from housing ineligible youth (those not subject to non-ambulatory restraint) or require that static restraint fixtures within the unit be removed or defeated. Subsection (e) of this section would prohibit jurisdictions from fabricating their own non-ambulatory restraint devices and require they purchase professionally manufactured and commercially available devices instead. The TJPC's research indicates that a professionally manufactured and commercially available restraint bed (with all necessary attachments) could cost anywhere from approximately $1,400.00 to $2,700.00 per unit. Subsection (f) of this section would require that non-ambulatory restraints lasting longer than one hour in duration are accompanied by the relevant recommendations submitted by a health care professional or a mental health professional. And finally, subsection (i) of this section requires that youth in non-ambulatory restraints be provided constant visual supervision by a juvenile supervision officer (i.e., detention officer). This may then require the allocation of additional JSOs.

Ms. Capers has also determined that for each year of the first five years the new rules are in effect, the public benefit expected as a result of enforcement or implementation will be the improved conditions of confinement for youth incarcerated in the State's secure pre and post-adjudication juvenile facilities and enhanced training credentials for the direct care staff serving and supervising these youth. There will be no impact on small business or individuals as a result of the amendments. Public comments on the proposed rules may be submitted in writing to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Kristy.Almager@tjpc.state.tx.us* or faxed to (512) 424-6718.

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§343.100, 343.102, 343.104, 343.106

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.100. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless otherwise expressly defined within the chapter.

(1) Acting Facility Administrator--The certified juvenile supervision officer who is designated in writing by the facility administrator to be in charge during his or her absence.

(2) Behavioral Health Assessment--A mental health assessment conducted by a Masters-level counselor with Texas State licensure (i.e., LPC, LMFT and LCSW) that includes information from testing, review of background information and clinical interview(s). See the Commission's commentary of §343.600 of this chapter for a complete listing of the specific elements required to be addressed in this assessment.

(3) Chief Administrative Officer--Regardless of title, the person hired by a juvenile board who is responsible for oversight of the day-to-day operations of a juvenile probation department for a single county or a multi-county judicial district.

(4) Commission--The Texas Juvenile Probation Commission (TJPC).

(5) Common Activity Area--Area inside the facility to which residents have access and in which activities are conducted. This area includes, but is not limited to dayrooms, covered recreation areas, recreation rooms, education rooms, counseling rooms, testing rooms, visitation areas, and medical or dental rooms.

(6) Contraband--Any item not issued to employees for the performance of their duties and which employees have not obtained supervisory approval to possess. Contraband also includes any item given to a resident by an employee or other individual, which a resident is not authorized to possess or use. Specific items of contraband include, but are not limited to:

(A) firearms;

(B) knives;

(C) ammunition;

(D) drugs;

(E) intoxicants;

(F) pornography; and

(G) any unauthorized written or verbal communication brought into or taken from an institution for a resident, former resident, associate of or family members of a resident.

(7) Date and Time of Admission--The date and time a juvenile has been authorized for detention in a secure pre-adjudication detention facility by an individual who is authorized by the juvenile board in accordance with §53.02 of the Texas Family Code. If the decision to detain was made prior to the juvenile's arrival to the facility, the date and time of admission shall be the same as the date and time of entry.

(8) Date and Time of Entry--The date and time a juvenile has been presented by law enforcement or county juvenile probation officer to a pre-adjudication secure detention facility for processing and authorization of detention.

(9) Design Capacity--The number of people that can safely occupy a building or space as determined by the current architectural design and any building modifications, licensing, accreditation, regulatory authorities, and applicable building codes.

(10) Designee--The person authorized to perform a specific duty as assigned by the facility administrator.

(11) Detention--The temporary secure custody of a child as defined in and authorized by Title 3 of the Texas Family Code.

(12) Disciplinary Seclusion--The separation of a resident from other residents for disciplinary reasons, and the placement of the resident alone in an area from which egress is prevented.

(13) Facility Administrator--Individual designated by the chief administrative officer or the governing board of the facility as the on-site program director or superintendent of a secure facility.

(14) Furlough--A period of time during which a resident is allowed to leave the facility premises and go into the community unsupervised for various purposes consistent with public interest.

(15) Hazardous Material--Any substance which is explosive, flammable, combustible, poisonous, corrosive, irritating or otherwise harmful and is likely to cause injury or death.

(16) Health Administrator--A person, who by virtue of education, experience or certification (e.g., MSN, MPH, MHA, FACHE, CCHP, MD), is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for juveniles.

(17) Health Assessment--The process whereby the health status of an individual is evaluated, which may include questioning the patient regarding symptoms.

(18) Health Care Professional--A term that includes physicians, physician assistants, nurses, nurse practitioners, dentists, mental health professionals, medical and nursing care assistants, emergency medical technicians (EMT), and others who, by virtue of their education, credentials and experience, are permitted by law to evaluate and care for patients.

(19) Health Service Authority--The agency, organization, entity or individual responsible for consulting and collaborating with the facility administrator and/or the health services coordinator to ensure a coordinated and adequate health care system is available to residents of the facility.

(20) Housing Area--An area within a secure juvenile facility that contains any single occupancy housing unit or units (SOHU) and/or multiple occupancy housing unit or units (MOHU).

(21) Housing Unit--A unit within the housing area that may be designed and constructed as either a single occupancy housing unit (SOHU) or a multiple occupancy housing unit (MOHU).

(22) Individual Resident Sleeping Quarter--A cell or room designed and constructed to securely house one resident.

(23) Intra-Jurisdictional Custodial Transfer--The transfer of a resident from a pre-adjudication secure detention facility into a post-adjudication secure correctional facility under the same administrative authority.

(24) Isolation--The separation of a resident from other residents and the placement of the resident alone in an area from which egress is prevented for assessment, medical, or protective purposes.

(25) Juvenile--A person who is under the jurisdiction of the juvenile court, confined in a juvenile justice facility, or participating in a juvenile justice program administered or operated under the authority of the juvenile board.

(26) Juvenile Supervision Officer--A person whose primary responsibility and essential function is the supervision of juveniles in a juvenile justice facility or a juvenile justice program operated by or under contract with the juvenile board.

(27) Material Safety Data Sheet (MSDS)--A document prepared by the supplier or manufacturer of a product clearly stating its hazardous nature, ingredients, precautions to follow, health effects and safe handling/storage information.

(28) Mental Health Assessment--An assessment that can only be completed by a licensed mental health professional. An assessment consists of gathering key information regarding the psychosocial needs and problems identified during a mental health screening, including the type and extent of mental health disorders and substance abuse disorders, other issues associated with the disorders and recommendation for treatment intervention.

(29) Medical Entity--An agency or organization that is primarily composed of health care professionals.

(30) Medical Treatment--Medical care, including diagnostic testing (e.g., x-rays, laboratory testing, etc.), performed or ordered by a physician, physician assistant, licensed nurse practitioner, emergency medical technician (EMT), or paramedic.

(31) Mental Health Professional--Including associates, students, interns, fellows, post-doctorates, or other approved students in an official training program in psychology or a related field under the supervision of an authorized, licensed supervising mental health professional. A mental health professional is an individual who has met the educational requirements and is licensed or certified by one or more of the following governmental entities:

(A) the Texas State Board of Examiners of Psychologists;

(B) the Texas State Board of Examiners of Professional Counselors;

(C) the Texas State Board of Examiners of Marriage and Family Therapists;

(D) the Texas Department of State Health Services;

(E) the Texas State Board of Medical Examiners;

(F) the Texas State Board of Social Work Examiners provided that the licensure is Licensed Clinical Social Work; or

(G) the Texas State Board of Social Work Examiners provided that the licensure is Licensed Master Social Work accompanied with written recognition by the board for independent practice.

(32) Mental Health Screening--A process that includes a series of questions that are designed to identify a resident who is at an increased risk of having mental health disorders that warrant attention and a professional review.

(33) Military-Style Program--A program or component in a post-adjudication secure correctional facility for juvenile offenders that features military-style discipline and structure as an integral part of its treatment and rehabilitation program.

(34) Multiple Occupancy Housing Unit (MOHU)--A housing unit designed and constructed for multiple occupancy sleeping which is self-contained and includes appropriate sleeping, sanitation, and hygiene equipment or fixtures.

(35) National Crime Information Center (NCIC)--NCIC is the Federal Bureau of Investigation (FBI) database utilized for the tracking of an individual's criminal history in the United States.

(36) Non-Program Hours--Time period when all scheduled resident activity for the entire resident population in the facility has ceased for the day.

(37) Physical Training Program--Any program that requires participants to engage in and perform structured physical training and activity. This does not include recreational team activities or activities related to the educational curriculum (i.e., physical education).

(38) Positive Screening--A scored result of a completed mental health screening instrument (i.e., MAYSI-2) recommending services requiring a primary service by a mental health professional as described on the MAYSI-2 reference card.

(39) Post-Adjudication Secure Correctional Facility ("Facility" or "Secure Facility")--A secure facility administered by a governing board that includes construction and fixtures designed to physically restrict the movements and activities of the residents and is intended for the treatment and rehabilitation of youth who have been adjudicated. Subchapters A, B, D and E of this chapter apply to all post-adjudication secure correctional facilities. A post-adjudication secure correctional facility does not include any non-secure residential program operating under the authority of a governing board.

(40) Pre-Adjudication Secure Detention Facility ("Facility" or "Secure Facility")--A secure facility administered by a governing board that includes construction and fixtures designed to physically restrict the movements and activities of juveniles or other individuals held in lawful custody in the facility and is used for the temporary placement of any juvenile or other individual who is accused of having committed an offense and is awaiting court action, an administrative hearing, or other transfer action. Subchapters A, B, C and E of this chapter apply to all pre-adjudication secure detention facilities. A pre-adjudication secure detention facility does not include a short-term detention facility as defined by §51.12(j) of the Texas Family Code.

(41) Premises--A building(s) together with its grounds or other appurtenances.

(42) Primary Control Room--A restricted or secure area from which entrance into and exit from a secure facility is controlled. The primary control room also contains the emergency, monitoring, and communications systems and is staffed 24 hours each day that residents are in the facility.

(43) Professionals--The following persons are considered professionals for limited purposes:

(A) teachers certified as educators by the State Board for Education Certification including teachers certified by the State Board for Education Certification with provisional or emergency certifications;

(B) educational aides or paraprofessionals certified by the State Board for Education Certification;

(C) health care professionals licensed or certified by:

(i) the Texas Board of Nurse Examiners;

(ii) the Texas Board of Medical Examiners;

(iii) the State Board of Physician Assistants;

(iv) the Texas Department of State Health Services; or

(v) the Texas State Board of Dental Examiners;

(D) mental health professionals as defined herein;

(E) qualified mental health professional as defined herein;

(F) social workers licensed by the Texas Board of Social Worker Examiners;

(G) juvenile probation officers certified by the Texas Juvenile Probation Commission; and

(H) commissioned law enforcement personnel.

(44) Protective Isolation--The exclusion of the threatened resident from the group by placing the resident in an individual room that minimizes contact with the residents from a specific group.

(45) Program Hours--Time period of no less than ten hours when the resident population has scheduled activities and any shift changes that occur during the time period when the resident population has scheduled activities.

(46) Qualified Mental Health Professional--An individual employed by the local mental health authority or an entity who contracts as a service provider with the local mental health authority who meets the guidelines of the Texas Department of State Health Services.

(47) Rated Capacity--The maximum number of beds available in a facility that were architecturally designed as a housing unit.

(48) Resident--A juvenile or other individual that has been lawfully admitted into a juvenile pre-adjudication secure detention facility or a post-adjudication secure correctional facility.

(49) Secondary Screening--A triage process that is brief and designed to clarify if a resident is in need of intervention or a more

comprehensive assessment and what type of intervention or assessment is needed.

(50) Serious Mental Illness--A professional diagnosis of the following disorders: psychoses, schizophrenia, bipolar with psychotic features, depression with psychotic features, severe post-traumatic stress disorder, and schizoaffective disorders.

(51) Single Occupancy Housing Unit (SOHU)--A housing unit designed and constructed with separate and secure individual resident sleeping quarters and includes appropriate sleeping, sanitation, and hygiene equipment or fixtures.

(52) Standard Screening Instrument--An instrument approved by the Commission that screens the juvenile's needs in the area of mental health.

(53) Texas Crime Information Center (TCIC)--TCIC is the Department of Public Safety database utilized for the tracking of an individual's criminal history in the State of Texas.

(54) Volunteer--Individuals agreeing to perform services without compensation, who have regular or periodic supervised contact or unsupervised contact with juveniles under the direction of the pre-adjudication and post-adjudication secure juvenile facility.

(55) Youth-on-Youth Sexual Conduct--Two or more juveniles, regardless of age, who engage in deviate sexual intercourse, sexual contact, sexual intercourse, or sexual performance as those terms are defined herein:

(A) "Deviate sexual intercourse" means:

(i) any contact between any part of the genitals of one person and the mouth or anus of another person; or

(ii) the penetration of the genitals or the anus of another person with an object.

(B) "Sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(i) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a person; or

(ii) any touching of any part of the body of a person, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(C) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(D) "Sexual performance" means acts of a sexual or suggestive nature performed in front of one or more persons, including simulated or actual sexual intercourse, deviate sexual intercourse, sexual bestiality, masturbation, sado-masochistic abuse or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.

(E) A juvenile may not consent to the acts as defined herein under any circumstances. Consent may not be implied regardless of the age of the juvenile.

§343.102. Interpretation and Applicability.

(a) Headings. The headings in this chapter are for convenience only and are not intended as a guide to the interpretation of the standards herein.

(b) Including. The word "including", when following a general statement or term, is not to be construed as limiting the general statement or term to any specific item or manner set forth or to similar items or matters, but, rather, as permitting the general statement or term to refer also to all other items or matters that could reasonably fall within its broadest possible scope.

(c) Applicability. This chapter applies to all secure juvenile pre-adjudication detention facilities and post-adjudication correctional facilities in this State, except for a facility operated or certified by the Texas Youth Commission. This chapter does not apply to a facility that is licensed by a state governmental entity or that is exempt from licensure by state or federal law. Furthermore, all standards requiring written policies and procedures are expected to be implemented and practiced.

(d) Compliance Resource Manual and Implementation of Agency Policy. The Commission may establish by administrative rule or other reasonable agency policy, the required guidelines, procedures, and documentation necessary to ensure compliance and verification of the standards set forth in this chapter.

§343.104. Waiver.

Unless expressly prohibited by another standard, the governing board, the chief administrative officer, or facility administrator may make an application for waiver of any standard or standards adopted by the Commission in accordance with Chapter 349 of this title.

§343.106. Variance.

Unless expressly prohibited by another standard, the juvenile board may make an application for variance of any standard or standards adopted by the Commission in accordance with §349.2 of this title.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268, 343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, 343.386

These standards are proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.200. Authority to Operate Secure Juvenile Facility.

Pursuant to Texas Family Code Title 3, a pre-adjudication secure detention facility and a post-adjudication secure correctional facility for juvenile offenders may only be operated by:

(1) a governmental unit in this State; or

(2) a private entity under a contract with a governmental unit in this State.

§343.202. Acceptance of Residents.

A facility may only accept and admit a child, as that term is defined in §51.02(2) of the Texas Family Code, who:

(1) has been charged with or adjudicated of an offense or offenses against the laws of this State;

(2) is authorized to be detained or confined pursuant to Title 3 of the Texas Family Code; or

(3) is a juvenile adjudicated of offenses committed against the laws of another state or the United States whose confinement is authorized pursuant to Chapter 342 of this title.

§343.204. Facility Governing Board.

Each facility shall have a governing board that functions in an oversight capacity to the facility. The governing board shall be a governmental unit or a board of trustees appointed by the governmental unit that establishes and operates or contracts for the establishment and operation of the facility. The governing board for the facility shall provide oversight of facility operations, policies and procedures.

§343.206. Certification and Registration of Facility.

Before admitting residents, the juvenile board in the county where the facility is located, shall:

(1) certify the facility in compliance with §51.12 or §51.125 of the Texas Family Code;

(2) designate the number of pre-adjudication and post-adjudication beds in the facility certification;

(3) register the facility with the Commission in compliance with §51.12 or §51.125 of the Texas Family Code; and

(4) post within a public area of the facility the current facility certification and the Commission's facility registration.

§343.208. Policy, Procedure and Practice.

The governing board of the facility shall require that written policies and procedures exist governing the operation of all secure juvenile pre-adjudication detention and post-adjudication correctional facilities in the county. The policies, procedures and practices of the facility shall include:

(1) a policy in the following areas strictly prohibiting:

(A) physical, sexual or emotional abuse, neglect or exploitation of a resident by any individual having contact with a resident of the facility;

(B) youth-on-youth sexual conduct between residents;

(C) violations of the juvenile supervision officer code of ethics and code of conduct as outlined in Chapter 345 of this title;

(D) violations of any professional code of ethics or conduct by any individual providing services to or having contact with residents of the facility; and

(2) a zero tolerance policy and practice regarding sexual abuse in accordance with the Prison Rape Elimination Act of 2003 that provides for administrative and/or criminal disciplinary sanctions.

§343.210. Designation and Qualifications of Facility Administrator.

(a) The chief administrative officer or the governing board of the facility or their designee shall designate a single facility administrator for each secure facility.

(b) The facility administrator shall:

(1) have acquired a bachelor degree conferred by a college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board;

(2) have either:

(A) one year of graduate study in criminology, corrections, counseling, law, social work, psychology, sociology, or other field of instruction approved by the Commission; or

(B) one year of experience in full-time case work, counseling, or community or group work:

(i) in a social service, community, corrections, or juvenile agency that deals with offenders or disadvantaged persons; and

(ii) the Commission determines the kind of experience necessary to meet this requirement; and

(3) maintain an active Commission certification as a juvenile supervision officer.

§343.212. Duties of Facility Administrator.

(a) The facility administrator shall be responsible for the daily operations of the facility and shall maintain an office at the facility.

(b) The facility administrator shall designate a certified juvenile supervision officer to be in charge during his or her absence from the facility.

(c) The facility administrator shall develop, implement and maintain a policies and procedures manual for the facility and shall ensure the daily facility practice conforms to the policies and procedures detailed in the manual.

(d) The facility administrator shall review the facility's policies and procedures manual at least every 365 calendar days and maintain documentation of this review.

(e) The facility administrator shall make available the policies and procedures manual to all employees of the facility.

(f) The facility administrator shall ensure that all employees of the facility are:

(1) trained on the policies and procedures manual provisions relevant to the employee's job functions during new employee orientation or prior to beginning service at the facility and maintain documentation of that training; and

(2) provided or made available, in a written or electronic format, all changes or modifications to the policies and procedures manual in a timely manner.

(g) The facility administrator or designee shall ensure that current, accurate and confidential personnel records are maintained for each employee which shall include:

(1) proof of age;

(2) documentation of criminal background checks conducted as required by this title;

(3) the completed application for employment;

(4) training records; and

(5) documentation of promotion, demotion, termination and other personnel actions.

(h) The facility administrator or chief administrative officer shall provide the presiding officer of the juvenile board or governing board of the facility with periodic updates on the operation of the facility, including the following information to be provided at least every quarter:

(1) facility population/capacity reports;

(2) number of serious incidents by category that occurred in the facility;

(3) number of resident restraints by type (e.g., personal, mechanical and chemical);

(4) number of injuries to residents requiring medical treatment; and

(5) number of injuries to staff requiring medical treatment.

(i) The facility administrator or chief administrative officer shall ensure the accurate and timely submission of statistical data to the Commission in an electronic format or other format as requested by the Commission.

(j) The facility administrator or chief administrative officer shall ensure that all individuals employed by the facility who have unsupervised contact with residents are subjected to all required criminal history background checks as required by Chapter 344 of this title.

§343.214. Data Collection.

The facility administrator or chief administrative officer shall maintain and report to the Commission electronically, or in the format requested, accurate statistics in the following areas:

(1) total number of grievances;

(2) total number of personal restraint incidents;

(3) total number of mechanical restraint incidents;

(4) total number of chemical restraint incidents;

(5) total number of non-ambulatory restraint incidents;

(6) total number of disciplinary seclusions; and

(7) total number of detention staff injuries resulting from interaction with residents.

§343.218. Location and Operations.

(a) Co-located Facilities.

(1) If the facility is located in the same building or on the grounds of any type of adult corrections facility, it shall be a separate, self-contained unit.

(2) All applicable federal and state laws pertaining to the separation of juveniles from adult inmates shall apply.

(3) The facility shall submit information and agree to monitoring from the Office of the Governor and/or the contract representative.

(b) Separate Operations.

(1) All pre-adjudication programs shall be operated separately from any post-adjudication programs.

(2) Where a pre-adjudication program and a post-adjudication program are located in the same building or on the same grounds, contact between the two populations shall be kept to a minimum.

(c) Non-Secure Programming on Facility Premises. Any youths who participate in day programming on the facility premise who are not residents of the facility shall be kept physically separated from residents of the facility at all times.

§343.220. Population.

The population of the facility shall not exceed the rated capacity of the facility.

§343.222. Heating and Ventilation.

(a) The facility shall provide fully functioning heating, cooling and ventilation systems adequate for the square footage of the facility.

(b) Alternate means of ventilation in the facility shall be maintained in case regular power is interrupted.

§343.224. Alternate Power Source.

(a) The facility shall have an alternate source(s) of electrical power that provides for the simultaneous operations of life safety systems including:

(1) emergency lighting;

(2) illuminated emergency exit lights and signs;

(3) emergency audible communication systems and equipment;

(4) fire detection and alarm systems;

(5) ventilation and smoke management systems; and

(6) all secure door locking mechanisms which operate exclusively on electric current.

(b) The alternate power source system shall be tested at least every fifteen (15) calendar days to ensure the system is in working condition.

(c) The alternate power system (e.g., the alternate power source and the life safety systems required to be operated) shall be inspected at least every 365 calendar days. This inspection must be completed by a person with qualifications established through work experience, relevant training, specialized licensure or certification.

(d) All of the aforementioned tests shall be documented to minimally include test date and test results.

(e) Any system malfunctions or maintenance needs that are identified during a test, or at any other time, shall require that a written maintenance request be immediately submitted to the appropriate personnel.

§343.226. Lighting.

(a) Lighting. Adequate lighting shall be provided to all areas of the facility.

(b) Natural Lighting. All housing units shall provide natural light available from a source within the housing unit. This standard also applies to all specialized housing.

§343.228. Dining Area.

The dining area shall provide a minimum of 15 square feet of floor space per diner.

§343.230. Specialized Housing.

Any room utilized for the disciplinary seclusion, protective isolation, assessment isolation or medical isolation of residents from the general population during program hours shall be equipped with:

(1) an operable toilet above floor level;

(2) a washbasin with hot and cold running water; and

(3) a bed above floor level.

§343.232. Housing for Residents with Physical Disabilities.

All housing areas used by residents with a physical disability shall be designed for their use and provide for their safety and security in accordance with state and federal law.

§343.234. Program Areas.

The facility shall provide space for:

(1) visitation;

(2) religious activities;

(3) interviewing and counseling; and

(4) educational instruction.

§343.236. Secure Storage Areas.

(a) Cleaning Supplies. Storage of cleaning supplies and equipment shall be locked and not accessible to residents.

(b) Restraint Devices. There shall be a location for secure storage of restraining devices and related security equipment. This equipment shall be readily accessible to authorized persons.

(c) Personal Property. Space shall be provided for secure storage of the resident's personal property.

§343.238. Hazardous Materials.

(a) The facility shall maintain an inventory and a copy of the Material Safety Data Sheet (MSDS) for all hazardous materials located in the facility.

(b) The facility shall prohibit the use of all hazardous materials by residents.

(c) Exceptions. Materials manufactured specifically for cleaning purposes may be used by residents for cleaning areas of the facility under the constant supervision of the juvenile supervision officer. The resident must be provided instruction on the use of the hazardous material and the proper equipment as prescribed by the MSDS.

(d) Any use of hazardous materials shall be used according to the manufacturer's instructions.

§343.240. Safety Codes.

(a) The facility shall conform to the provisions set forth in the Life Safety Code, National Fire Protection Association (NFPA) 101 and/or any applicable state and local fire safety codes. The Life Safety Code may be substituted with local government ordinances or codes only if said ordinances or codes are specifically written to include building occupancy for detention and correctional usage.

(b) A formalized Life Safety Code Inspection/fire safety inspection shall be completed prior to the facility becoming operational.

(c) All subsequent Life Safety Code Inspections/fire safety inspections shall be conducted no later than 365 calendar days from the date of previous inspection.

(d) Each Life Safety Code/fire safety inspection shall result in a written report that minimally contains the following information:

(1) the identification of the specific code(s) used to complete the inspection. The code(s) in question will either be the NFPAs Life Safety Code 101 or the applicable state, municipal or county specific fire code adopted by the jurisdiction;

(2) the name of the governmental entity that conducted the inspection;

(3) the identification of any applicable code violations or infractions and the corresponding corrective action requirements;

(4) the name and title of the person conducting the inspection; and

(5) the date(s) of the inspection.

(e) Any deficiencies noted in the annual inspection report shall be immediately addressed by the facility administrator or designee. The facility administrator shall develop and document a corrective action plan to rectify all deficiencies.

§343.242. Fire Safety Plan.

(a) The facility shall have in effect and available to all supervisory personnel, written copies of a fire safety plan for the protection of all persons in the event of a fire for their evacuation to areas of refuge and for their evacuation from the building if necessary.

(b) The fire safety plan shall be coordinated with and reviewed by the fire department whose jurisdiction includes the facility. The coordination and review efforts required in this standard shall be validated by written documentation prepared or attested to by a representative of the applicable fire department.

(c) The fire safety plan shall require that all employees be instructed to ensure the following:

(1) proper disposal of combustible refuse;

(2) prompt evacuation of the facility; and

(3) procedures for the use and control of flammable, toxic, and caustic materials.

§343.244. Fire Safety Officer.

The fire safety officer shall:

(1) ensure maintenance of a current fire drill log;

(2) ensure that fire drills are conducted as required by §343.246 of this chapter;

(3) ensure the posting of a plan for prompt evacuation of the facility as required by §343.246 of this chapter;

(4) implement procedures for proper disposal of combustible refuse; and

(5) implement procedures for the use and control of flammable, toxic, and caustic materials.

§343.246. Fire Drills.

(a) Required Fire Drills. The fire safety officer or designee shall conduct fire drills on all shifts at least every ninety calendar days.

(b) All staff on duty in the facility shall participate in the fire drills.

(c) Exits. Facility exits shall be clear of obstruction and properly marked for evacuation in the event of fire or other emergency.

(d) Evacuation Plans. Facility emergency evacuation plans shall be posted in resident restricted areas.

§343.248. Non-Fire Emergency Preparedness Plan.

The facility shall have an emergency preparedness plan that includes, but is not limited to severe weather, natural disasters, disturbances or riots, national security issues, and medical emergencies. The plan shall address:

(1) the identification of key personnel and their specific responsibilities during an emergency or disaster situation;

(2) agreements with other agencies or departments; and

(3) transportation to pre-determined evacuation sites.

§343.249. Internal Security.

(a) Policies and Procedures. Written policies and procedures for security and control of the facility shall include the following:

(1) continued operations in the event of a work stoppage;

(2) key control;

(3) control of the use of:

(A) tools;

(B) medical equipment; and

(C) kitchen tools;

(4) provisions to prevent firearms from entering the secure area of the facility; and

(5) provisions for coordination with law enforcement authorities in the case of escape or other situations requiring assistance from city, county or state law enforcement agencies.

(b) Documentation.

(1) The facility administrator or designee shall ensure the documentation of all special incidents, including, but not limited to the taking of hostages, escapes, and assaults.

(2) A copy of the report shall be placed in the permanent file of any resident(s) involved in the incident.

(c) Video and Audio Surveillance. Video and audio monitoring devices may be utilized for security purposes but shall not substitute for required levels of supervision by a juvenile supervision officer.

§343.250. External and Perimeter Security.

(a) The facility shall be constructed so that residents remain within the premises and the general public is denied access without authorization.

(b) Perimeter security shall be maintained at all times. Any outdoor area in which residents are permitted shall be enclosed by a permanently erected fence or wall to help prevent resident escapes and unauthorized public entry to the facility grounds.

§343.260. Resident Searches.

(a) Residents shall only be subjected to the following searches:

(1) a pat down or frisk search as necessary for facility security and safety;

(2) an oral cavity search to prevent concealment of contraband, to ensure the proper administration of medication;

(3) a strip search in which the resident is required to surrender their clothing based on the reasonable belief that the resident is in possession of contraband or if there is reasonable belief that the resident presents a threat to the facility's safety and security;

(A) a strip search shall be limited to a visual observation of the resident and shall not involve the physical touching of a resident;

(B) a strip search shall be performed in an area that ensures the privacy and dignity of the resident; and

(C) a strip search shall be conducted by a staff member of the same gender as the resident being searched;

(4) an anal or genital body cavity search only if there is probable cause to believe that they are concealing contraband;

(A) an anal or genital body cavity search shall be conducted only by a physician; and

(B) all anal and genital body cavity searches shall be conducted in an office or room designated for medical procedures; and

(C) all anal and genital body cavity searches shall be documented with the documentation being maintained in the resident's file.

(b) During searches, the residents shall not be touched any more than necessary to conduct a comprehensive search; and

(c) Every effort shall be made to prevent embarrassment or humiliation of the resident.

§343.262. Hygiene Plan.

Residents shall be given appropriate instruction on hygiene and shall be required to comply with acceptable rules of personal cleanliness and oral hygiene.

§343.264. Personal Hygiene.

Residents shall be required to shower daily.

§343.266. Bedding.

(a) Each resident shall be provided suitable clean bedding, including two sheets, a pillow and a pillowcase, a mattress, and a blanket. Mattresses with an integrated pillow may be substituted for a separate pillow and a pillowcase.

(b) Clean bed linens shall be issued at least every seven calendar days.

(c) Modifications to a resident's bedding items may be made in accordance with §343.340(a)(8) of this chapter.

(d) In no case, shall residents on suicide supervision be denied appropriate bedding substitutions.

§343.268. Towels.

A clean towel shall be issued to each resident daily.

§343.270. Clothing.

(a) Clean clothing shall be provided to each resident upon admission into the facility.

(b) Clean and disinfected undergarments and socks shall be issued daily and other clean clothing shall be issued at least twice per week.

(c) Climate appropriate clothing shall be provided to all residents in the facility for any outdoor programming or activities.

(d) A resident on suicide supervision status may have their clothing requirements modified per the facility's suicide prevention plan in §343.340 of this chapter. However, in no case shall residents on suicide supervision be left in an unnecessary state of undress.

§343.272. Housekeeping Plan.

A written housekeeping plan shall be followed which promotes and ensures cleanliness, facility sanitation, and control of vermin and pests.

§343.274. Resident Discipline Plan.

Each facility shall develop and implement a written resident discipline plan that provides for the fair and consistent application of resident rules and sanctions. A resident discipline plan shall minimally include:

(1) resident rule violations categorized into minor infractions and major infractions as well as the corresponding sanctions available to staff. Minor infractions shall be limited to those rules which do

not represent serious offenses against persons or property and do not pose a serious threat to institutional order and safety. Major infractions shall be limited to those rules which constitute serious offenses against persons or property and pose a serious threat to institutional order and safety;

(2) provisions to ensure that rule infractions or resident behaviors which constitute probable cause for an offense of a class B misdemeanor or above shall be referred to the law enforcement agency with applicable jurisdiction for possible investigation and/or prosecution;

(3) a listing of prohibited sanctions for residents that minimally includes:

(A) corporal punishment;

(B) humiliating punishment;

(C) allowing or directing one resident to sanction another;

(D) group punishment for the acts of individuals;

(E) deprivation or modification of required meals and snacks;

(F) deprivation of clean and appropriate clothing;

(G) deprivation or intentional disruption of scheduled sleeping opportunities;

(H) deprivation or intentional delay of medical and mental health services; and

(I) physical exercises imposed for the purposes of compliance, intimidation, or discipline;

(4) provisions that a resident shall be provided written notice of the alleged rule violation against him or her no more than 24 hours after the violation;

(5) provisions for an informal process for residents to resolve conflict with rule infractions and the corresponding sanctions, if the facility chooses to employ such a process; this shall include established guidelines that provide instruction for residents and staff in using this informal process to review and resolve resident concerns. In no case, shall a resident be sanctioned or retaliated against for electing to forego the informal disciplinary review process when they are eligible for formal disciplinary reviews;

(6) provisions for disciplinary reviews for major rule infractions, including established requirements of when to initiate formal disciplinary reviews and any ensuing appeals. The facility's policies and procedures shall not deny or restrict a formalized disciplinary review or appeal when one is requested by a resident with eligible standing; and

(7) provisions for the administrative review and closure of formal disciplinary reviews that are not disposed of prior to a resident's discharge from the facility.

§343.276. Formal Disciplinary Reviews for Major Rule Infractions.

Residents that receive a major rule violation or sanction are eligible to request a formal disciplinary review. Upon such a request, a resident shall receive a formal disciplinary review within ten calendar days.

§343.278. Formal Disciplinary Reviews for Residents in Disciplinary Seclusion.

(a) Residents in disciplinary seclusion shall receive the following due process reviews during the period of their seclusion. The reviews in paragraphs (1) and (2) of this subsection shall be conducted in a face-to-face setting by supervisory-level staff which shall not include any staff member involved in the alleged rule violation or the imposed sanction(s). Each of these two review procedures shall be appropriately documented and the corresponding documentation shall be retained in the resident's file. The following procedures shall be conducted:

(1) Upon the twenty-fourth hour of seclusion the resident shall receive an informal disciplinary review which includes an overview of the facility's formal disciplinary review process. If the twenty-fourth hour of seclusion occurs during non-program hours, then the informal review shall be conducted no later than 2 hours after the start of ensuing day's program hour schedule.

(2) A resident assigned to an extended period of seclusion beyond 24 hours shall have a formal disciplinary review no later than his or her seventy-second hour of seclusion per §343.280 of this chapter. If the seventy-second hour of seclusion occurs during non-program hours, then the formal disciplinary review shall be conducted no later than two hours after the start of the ensuing day's program hour schedule.

(b) A resident may choose to waive the right to a disciplinary review provided proper notification is given prior to the signing of the waiver. The waiver shall include the applicable rule violation and sanction plan.

§343.280. Formal Disciplinary Review Process.

The formal disciplinary review process shall, at a minimum, adhere to the following requirements:

(1) Disciplinary reviews must be before a neutral and impartial officer or board that shall not include any staff member involved in either the alleged rule violation or the imposed sanction.

(2) Provisions shall be made for the disclosure of the evidence against the resident accused with a rule violation on his or her behalf.

(3) A resident shall have the opportunity to be heard in person and to present evidence on his or her behalf.

(4) A resident shall have the opportunity to request relevant witnesses on his or her behalf.

(5) A resident shall have the opportunity to secure the aid of another resident or a staff member if the resident is illiterate or unable to understand the nature of the proceedings.

(6) If the disciplinary review determines that the resident did not commit a rule violation or that the corresponding sanction was inappropriate, facility staff shall restore or reinstate any denied or modified resident privileges.

(7) At the conclusion of a disciplinary review, a written statement by the disciplinary officer or disciplinary board shall be prepared indicating the evidence relied upon and justification for the disposition. The statement shall be made available to the resident for review and a copy shall be retained in the resident's file.

§343.282. Resident Appeals.

A resident may appeal the findings of a disciplinary review. The facility's resident discipline plan shall minimally include:

(1) provisions for a documented appeals process before the disciplinary officer or a person or persons not a member of the disciplinary board. The appeals process shall afford each of the due process provisions enumerated in §343.280(2) - (7) of this chapter;

(2) provisions that require the resident to submit the request for an appeal no later than 7 calendar days after a disposition is rendered in the disciplinary review;

(3) provisions that require the resident's appeal to be heard within thirty calendar days of resident's request; and

(4) provisions for a written statement by the appeals officer or appellate board at the conclusion of the review indicating the evidence relied upon and justification for the disposition. The statement shall be made available to the resident for review and a copy shall be retained in the resident's file.

§343.286. Room Restriction.

(a) Room restriction may be used in increments of up to 90 minutes for behavior modification.

(b) During room restriction, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed fifteen minutes.

§343.288. Disciplinary Seclusion.

(a) Disciplinary seclusion may be used when a resident commits a major rule violation or poses an imminent physical threat to self or others.

(b) A written disciplinary report which describes the resident's precipitating behavior and identifies the staff's response shall be completed promptly, but no later than the end of the shift on which the seclusion occurs. The report shall be submitted immediately to the facility administrator or the acting facility administrator for review.

(c) Seclusion in excess of 24 hours shall be approved in writing by the facility administrator or the acting facility administrator. The written approval of the facility administrator or the acting facility administrator shall also be required for each subsequent 24-hour extension.

(d) The seclusion of a resident with a known diagnosis of a serious mental illness requires consultation with a mental health professional prior to the authorization of any seclusion beyond a 24-hour period. If the seclusion occurs on a holiday or weekend and no mental health professional is available, the facility administrator or designee shall make a referral to the mental health professional and notify the mental health professional of the seclusion. The facility administrator or the acting facility administrator shall consult with the mental health professional as soon as possible after the referral.

(e) During disciplinary seclusion, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed fifteen (15) minutes.

(f) In addition to the requirements enumerated in subsections (a) - (c) and (e) of this section, the facility shall provide the secluded resident the disciplinary review mechanisms contained in §343.278 of this chapter.

§343.290. Protective Isolation.

(a) Protective isolation may be ordered when a resident is physically threatened by a resident or a group of residents.

(b) This decision shall be approved in writing by the facility administrator or the acting facility administrator.

(c) While in protective isolation, a juvenile supervision officer shall observe and record the resident's behavior at random intervals not to exceed fifteen (15) minutes.

(d) If the protective isolation of a resident exceeds 72 hours, the facility administrator or acting facility administrator shall immediately conduct a documented review of the circumstances surrounding the level of threat faced by the resident and make a determination as to whether other less restrictive protective measures are appropriate and available. If continued protective isolation is approved, the facility administrator, or acting facility administrator, shall ensure that the formalized written review document includes an alternative service delivery plan to ensure the isolated resident is afforded all required program services during their period of protective isolation.

§343.300. Nutritional Requirements.

Meals shall meet the dietary requirements of the United States Department of Agriculture (USDA).

§343.302. Menu Plans.

(a) The facility shall develop and follow daily written menu plans. Menu plans shall be reviewed and approved at least every 365 calendar days by a licensed or provisionally licensed dietician to ensure that the menu plans meet or exceed the requirements of the United States Department of Agriculture (USDA).

(b) If a facility staff determines that there is a legitimate need to deviate from an already approved written menu plan (e.g., delayed food delivery, spoiled/expired food, etc.), the reason for the deviation and menu substitution shall be fully documented. When menu substitutions are made, the substitution shall be of equal portions and nutritional value.

§343.304. Menu Content.

(a) Menus shall contain a variety of foods.

(b) The same menu or the same single meal shall not be served more than 2 consecutive days.

§343.306. Modified Diets.

Modified diets shall be provided upon the recommendation of a health care professional or when a resident's religious beliefs require it.

§343.308. Mealtime Prohibitions.

Residents shall not eat meals in their rooms unless it is necessary for facility safety and security (i.e., assignment to disciplinary seclusion, medical isolation, or assessment isolation or during riot or rebellion).

§343.310. Staff Meals.

Facility staff members on duty where residents are eating are not required to eat, but if they do, they shall eat the same food served to the residents unless a special diet has been ordered by a health care professional or a staff's religious beliefs require it.

§343.312. Daily Meal Schedule.

(a) Three meals shall be provided daily to each resident in the facility.

(b) At least 2 of the meals shall be hot.

(c) No more than fourteen hours may elapse between the evening meal and breakfast unless a snack is provided.

(d) Residents shall be allowed no less than ten minutes to eat once they have received their food.

§343.314. On-site Food Preparation.

A facility that prepares food on site shall maintain a valid permit and any required licenses issued by the local health department or the Texas Department of State Health Services.

§343.316. Off-site Food Preparation.

A facility that receives food from an off-site source shall maintain a copy of the source's valid permit and any required licenses issued by the local health department or the Texas Department of State Health

Services. The transfer of such food to the facility shall be conducted in a manner to prevent contamination or adulteration.

§343.320. Health Service Authority.

The facility shall have a designated health service authority responsible for the development and implementation of health care protocols within the facility. The health service authority shall be a physician, physician assistant, registered nurse, nurse practitioner, health administrator, or a medical entity. When a medical entity is designated as the health service authority, an individual shall be identified as the primary point of contact.

§343.322. Health Care Services.

(a) Health Service Plan. The facility shall have a written health service plan developed in consultation with the designated health service authority. The health service plan shall establish the facility's health care delivery system for all residents.

(b) Review of Health Service Plan. The health service plan shall be reviewed at least every 24 months in consultation with the health service authority.

§343.324. Health Services Coordinator.

(a) The facility shall have a designated health services coordinator on staff to coordinate health care delivery in the facility.

(b) If the health services coordinator is not a health care professional, the health services coordinator shall receive special training in health care and health care service delivery topics relevant to detention and correctional facilities and be familiar with local health care providers and facilities.

§343.326. Medical Referral.

If a staff member observes any resident to be in need of medical attention or if a resident requests medical attention, the resident shall be referred for medical services. The resident may not be denied access to health care if the resident will only disclose the condition or reason for the treatment request to a health care professional.

§343.328. Consent for Medical Treatment.

(a) Consent for medical treatment shall be secured in accordance with Chapter 32 of the Texas Family Code.

(b) Documentation of consent for medical treatment received, in accordance with Chapter 32 of the Texas Family Code, shall be maintained in the applicable resident files.

§343.330. Medical Treatment for Victims of Sexual Abuse.

Testing for sexually transmitted diseases, including HIV-AIDS, shall be made available to a resident who, at the conclusion of an internal investigation or Commission investigation of abuse, neglect or exploitation, is found to have been abused, neglected or exploited in a manner by which HIV-AIDS or any other sexually transmitted disease may have been transmitted. The cost of the testing services and any subsequent medical treatment services shall not be assessed to the resident or the resident's family.

§343.332. Behavioral Health Care Services for Sexual Abuse Victims.

A mental health professional shall assess any resident who, at the conclusion of an internal investigation or Commission investigation of abuse, neglect or exploitation that occurred in the facility, is found to have been the victim of a sexual assault. The mental health professional shall assess the need for crisis intervention counseling and any subsequent long-term, follow-up or counseling services. The cost of the assessment and any subsequent counseling services shall not be assessed to the resident or the resident's family.

§343.334. Confidentiality.

(a) All medical and mental health screenings and assessments shall be conducted in a confidential setting consistent with facility operations and security.

(b) All interactions between a resident and a health care professional that involve treatment or an exchange of confidential medical information shall be conducted in private. The facility's policies and procedures may authorize a juvenile supervision officer to be present in the following situations:

(1) if the resident poses a substantial risk to the safety of the health care professional or others;

(2) if the facility has a written policy requiring the presence of a juvenile supervision officer during medical treatment;

(3) if the health care professional or resident requests the presence of a juvenile supervision officer during the treatment; or

(4) if the circumstances or situation indicate the presence of a juvenile supervision officer is necessary and prudent.

§343.336. Prescription Medication.

(a) Use of Medication. Except upon the order of a physician, physician assistant, dentist or nurse practitioner, no stimulant, tranquilizer, or psychotropic drug shall be administered to residents.

(b) Medication Policy. In accordance with §142.005 of the Texas Human Resources Code, the juvenile board or governing board of the facility shall adopt a policy concerning the administration of medication to residents. The policy shall specify which facility personnel are authorized to administer medication to residents.

§343.338. Medical Isolation.

Medical isolation may be authorized as a health precaution at the direction of a health care professional, facility administrator or the acting facility administrator.

(1) The reasons for the medical isolation of a resident shall be documented and a copy placed in the resident's file.

(2) A resident that has been placed on medical isolation by a facility administrator or the acting facility administrator shall be seen by a health care professional within twelve hours of the initial medical isolation.

(3) During medical isolation, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed fifteen (15) minutes.

§343.340. Suicide Prevention Plan.

(a) Plan. The facility shall have a written suicide prevention plan developed in consultation with a mental health professional that, at a minimum, addresses the following components:

(1) definitions of moderate and high risk for suicidal behavior;

(2) a screening methodology to assess and assign a resident's risk of suicide upon admission into the facility, and upon any indication a resident previously screened may now be at moderate or high risk for suicidal behavior. The screening methodology shall include specific provisions regarding the assessment of risk when a resident refuses or is unable to cooperate with the screening process;

(3) communication protocols among facility staff, mental health professionals, the resident's juvenile probation officer, the resident and the resident's parent, legal guardian, or custodian, including communication regarding observations or indications a resident previously screened may now be at moderate or high risk for suicidal behavior;

(4) level of supervision for residents assigned to moderate or high risk for suicidal behavior;

(5) policies and procedures for intervening in suicide attempts;

(6) reporting of resident suicides and attempted suicides, in accordance with any applicable state law, administrative standard, or local policy or ordinance;

(7) staff training on the contents and implementation of the suicide prevention plan;

(8) housing of residents assigned to moderate or high risk for suicidal behavior, including the removal from the resident's presence any dangerous objects which may include clothing and bedding items; and

(9) mortality reviews designed to review the facility's compliance and possible needed revisions to the suicide prevention plan following a resident's suicide.

(b) Implementation. The facility shall implement the suicide prevention plan, and all residents shall be screened and assessed for suicide risk upon admission and as necessary thereafter.

§343.342. Review and Dissemination of Suicide Prevention Plan.

(a) The suicide prevention plan shall be reviewed every 365 calendar days in consultation with a mental health professional.

(b) The suicide prevention plan shall be disseminated or made available to all facility staff having responsibilities named or enumerated in the facility's suicide prevention plan.

§343.346. Mental Health Referral of High Risk Suicidal Youth.

(a) The facility shall refer a resident classified as high risk for suicidal behavior to a mental health professional or mental health agency within 24 hours from the time the resident is classified as such.

(b) The facility shall maintain written documentation that the referral was made. The documentation shall include:

(1) the name and title of the person who notified the mental health professional;

(2) the name and title of the mental health professional or name of the mental health agency notified;

(3) the date and time of the notification;

(4) the method of notification; and

(5) a brief description of the response provided by the mental health professional or a responsive document from the mental health professional.

§343.348. Supervision of High Risk Suicidal Youth.

(a) Observation. During non-program hours, or any time a resident classified as high risk for suicidal behavior is secluded from the general population:

(1) the resident shall be under the continuous, uninterrupted visual supervision of a juvenile supervision officer; and

(2) the supervising juvenile supervision officer shall document his or her personal observations of a high-risk resident at intervals not to exceed 30 minutes.

(b) Required Documentation. The following documentation shall be maintained for high-risk residents:

(1) the date and time the resident was classified as high risk for suicidal behavior;

(2) name and title of the person who classified the resident as high risk for suicidal behavior;

(3) a description of the resident's behavior and/or factors that led up to the resident's classification as high risk for suicidal behavior;

(4) name and title of the juvenile supervision officer providing supervision of the resident;

(5) the location of the resident's supervision;

(6) the date and time the resident was reclassified as no longer being high risk for suicidal behavior; and

(7) the name and title of the mental health professional or physician who recommended the reclassification of the resident as no longer being high risk for suicidal behavior.

(c) Reclassification. Reclassification of a resident designated as high risk for suicidal behavior to a lower risk level shall only be determined by a qualified mental health professional, a mental health professional or a licensed physician.

(1) Prior to being removed from a classification of high risk for suicidal behavior, a qualified mental health professional, mental health professional or a licensed physician shall conduct a review of the resident's current suicide risk and issue a written recommendation which addresses the following:

(A) the need to re-classify the resident's suicide risk level;

(B) the need for intervention strategies and/or services during the resident's period of confinement within the facility; and

(C) the need for additional assessment(s), screening(s) or evaluation(s).

(2) The written recommendation of the qualified mental health professional, mental health professional or licensed physician shall be maintained in the resident's record.

(3) The facility administrator or the acting facility administrator shall review the written recommendation of the qualified mental health professional, mental health professional or licensed physician prior to reclassifying a resident as no longer at high risk for suicidal behavior.

(4) Only the facility administrator or the acting facility administrator shall authorize the reclassification of a resident classified as high risk for suicidal behavior under this subsection.

§343.350. Supervision of Moderate Risk Suicidal Youth.

(a) Observation. Any time a resident is classified as a moderate risk for suicidal behavior and is in individual sleeping quarters, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed ten minutes.

(b) Required Documentation. When providing supervision at random intervals, the juvenile supervision officer shall document:

(1) the date and time the resident was classified as moderate risk for suicidal behavior;

(2) the location of the resident's supervision;

(3) the name and title of the juvenile supervision officer providing supervision of the resident;

(4) each visual observation made and the time of the observation; and

(5) a general description of the resident's behavior.

(c) Reclassification. Only the facility administrator or the acting facility administrator shall authorize the reclassification of a resident classified as moderate risk for suicidal behavior under this section.

§343.352. Visitation.

(a) Residents have the right to receive visitors and to communicate subject only to the limitations authorized in §343.354 of this chapter.

(b) Residents shall be allowed visitation by a parent, legal guardian or custodian at least once every 7 calendar days for at least thirty minutes or the equivalent over multiple visits.

(c) The parent, legal guardian or custodian of the resident shall be provided a copy of the visitation schedule.

(d) A registry of all visitors shall be maintained to document the name and relationship to the resident.

§343.354. Limitations on Visitation.

(a) The policies, procedures and practices of the facility may limit a resident's visitation rights only to the extent required to maintain control and security of the facility.

(b) Restrictions on a resident's visitation rights shall not be imposed as a disciplinary sanction.

(c) The facility administrator or the acting facility administrator shall provide written documentation justifying any restriction placed on a resident's visitation rights.

(d) A resident shall not be denied communication or visitation with a parent, legal guardian or custodian for a prescribed period of time after admission into the facility.

§343.356. Access to Attorney.

Residents shall be permitted reasonable confidential contact with the resident's attorney and their designated representatives through telephone, uncensored letters, and personal visits.

§343.358. Telephone.

(a) A resident shall be provided the opportunity for at least one 5 minute phone call every 7 calendar days.

(b) Restrictions on a resident's telephone usage shall not be imposed as a disciplinary sanction.

(c) The parent, legal guardian or custodian of the resident shall be provided a copy of the facility's policy regarding telephone usage.

§343.360. Mail.

(a) Residents shall be provided access to writing materials and postage for no fewer than 2 letters every 7 calendar days.

(b) When a resident is released or transferred from the facility, his or her mail shall be forwarded to the resident's new address.

(c) Money received in the mail shall be held for the resident in their personal property inventory, with receipt provided, or returned to the sender.

§343.362. Limitations on Mail.

(a) Authorized Limitations. A resident's rights to privacy and correspondence may not be limited except when:

(1) a reasonable belief exists to suspect that the correspondence is part of an attempt to formulate, devise, or otherwise effectuate a plan to escape from the facility, or to violate state or federal laws. If such cause exists, then facility staff shall:

(A) ask the resident's permission to read the letter;

(B) if permission is denied, request a search warrant prior to opening and reading the letter; and

(C) if a search warrant request is denied, the correspondence shall be provided to the resident;

(2) correspondence with certain individuals is specifically forbidden by:

(A) the resident's juvenile court-ordered rules of probation or parole;

(B) the facility's rules of separation; or

(C) a specific list of individuals furnished by a resident's parents, legal guardians or custodians indicating who they feel should not communicate with the resident.

(b) Returning Mail. Such incoming correspondence as identified in subsection (a)(2) of this section shall be returned unopened to the sender.

(c) Withholding Mail. When mail is withheld from the resident, the reasons shall be documented and a copy placed in the resident's file.

§343.364. Legal Correspondence.

Residents shall be furnished adequate postage for legal correspondence during their confinement in the facility.

§343.366. Inspection of Mail.

Mail may be opened by staff only in the presence of the resident with inspection limited to searching for contraband.

§343.368. Illegal Discrimination.

Residents shall not be subjected to discrimination based on race, national origin, religion, sex, or disability.

§343.370. Prohibited Supervision.

Residents shall not be subjected to supervision and control by other residents.

§343.372. Work by Residents.

(a) Residents may be required to perform the following types of work responsibilities without monetary compensation:

(1) assignments which are part of a formalized vocational training curriculum;

(2) tasks performed as a community service pursuant to a juvenile court order; and

(3) routine housekeeping chores which are shared by all youth in the facility, including general facility maintenance.

(b) Residents shall not be permitted to perform any work prohibited by state or federal regulations pertaining to child labor.

(c) Repetitive, purposeless, or degrading make-work is prohibited.

(d) A resident's work assignments shall be excused or temporarily suspended if medically contra-indicated.

(e) Residents shall be provided with the necessary supervision, appropriate tools, cleaning implements, and clothing to safely and effectively complete their assignments.

(f) Residents shall not perform personal services for staff.

§343.374. Experimentation and Research Studies.

(a) Experimentation. Participation by residents in medical, psychological, pharmaceutical, or cosmetic experiments is prohibited.

(b) Research Studies. Participation by residents in medical, psychological, pharmaceutical, or cosmetic research is prohibited unless the research study is approved in writing by the juvenile board subject to the following guidelines:

(1) The juvenile board shall promulgate approved policies that govern all authorized research studies. Studies that include medically invasive procedures shall be prohibited.

(2) Approved research studies shall adhere to all applicable policies of the authorizing juvenile board.

(3) Research studies approved by the juvenile board shall be reported to the Commission in a format prescribed by the Commission prior to the commencement of the study.

(4) The results of the study shall be made available to the Commission upon request from the facility administrator, chief administrative officer, or juvenile board.

(5) Policies governing research studies shall adhere to all federal requirements governing human subjects and confidentiality.

§343.376. Resident Grievance Process.

Written policies and procedures, as well as actual practices shall demonstrate that there is a formalized grievance process to address residents' complaints about their treatment and facility services. At a minimum, the formalized grievance process shall include the following policy, procedural, and practice elements:

(1) Residents' ability to submit a grievance with full access to the process;

(2) A written response and resolution to all complaints:

(A) shall be resolved no later than ten calendar days from the date the grievance is received by pre-adjudication staff; or

(B) shall be resolved no later than thirty calendar days from the date the grievance is received by post-adjudication staff;

(3) Confidentiality of grievance without fear of reprisal;

(4) The designation of staff(s) as grievance officer(s);

(5) At least 1 level of appeal to an administrative-level staff person or to an administrative-level appeals board or panel;

(6) The resident's ability to participate in the resolution of a grievance, including the use of an intermediary and the ability to request witnesses;

(7) Periodic formal reviews of the grievance process and dispositions by administrative-level staff;

(8) A tracking system and grievance log that accounts for all grievances submitted; and

(9) Unresolved grievances submitted by any resident who is released shall be forwarded to the facility administrator or designee to determine if any action is needed.

§343.378. Grievance Appeals.

(a) The appeal shall be decided in a timely manner after receipt.

(b) The resident shall promptly be notified in writing of the resolution.

§343.380. Grievance Officer.

The duties of a grievance officer shall include:

(1) the maintenance of a current grievance log;

(2) the daily collection of grievances;

(3) responding to the resident after receiving the grievance;

(4) providing a written resolution to the resident; and

(5) forwarding all appeals to the administrative staff responsible for determining appeals.

§343.382. Grievance Form.

The grievance form shall contain the following elements:

(1) the name of the resident;

(2) the housing unit or cell;

(3) the date of the grievance;

(4) the grievance tracking identification;

(5) the nature or description of the grievance;

(6) the date and time of receipt;

(7) the name and title of the person receiving the grievance;

(8) the response or resolution to the grievance;

(9) the date and time of the response;

(10) the name and title of the person responding to the grievance; and

(11) a space for a written request to appeal the grievance response.

§343.384. Religious Services.

Residents shall not be required to participate in religious services and religious counseling.

§343.386. Volunteers and Interns.

Facilities utilizing a volunteer or internship program shall have written policies and procedures that contain the following components:

(1) a description of the authority, responsibility and accountability of volunteers and interns who work with the department;

(2) the selection and termination criteria, including disqualification based on specified criminal history;

(3) the orientation and training requirements, including training on recognizing and reporting abuse, neglect and exploitation;

(4) a requirement that volunteers and interns meet minimum professional requirements if applicable; and

(5) a written volunteer and intern registry, log or other documentation that details all dates and times a volunteer or intern is present on the premises of the facility as well as the purpose of their visit.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER C. SECURE PRE-ADJUDICATION DETENTION FACILITY STANDARDS

37 TAC §§343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432, 343.434, 343.436, 343.438, 343.440, 343.442, 343.444, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, 343.498

These standards are proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.400. Intake and Admission.

(a) Intake. An intake officer authorized by the juvenile board shall be on duty at the facility or on-call 24 hours a day.

(b) Pre-Admission Assessment. Each facility shall have written policies and procedures addressing the admission of juveniles who are in need of emergency medical care due to injury, illness or intoxication or who are in need of emergency mental health services.

(1) Anyone presented for admission into detention and is in need of emergency medical care due to injury, illness or intoxication, or is in need of mental health intervention, shall not be admitted into detention.

(2) The referring person shall be directed to a health care facility to have the individual evaluated and treated.

(c) Subsequent admission into detention is contingent upon written medical clearance provided by a health care or mental health professional.

(d) Intoxicated or Chemically Impaired Individuals. Each facility shall have written policies and procedures addressing intoxicated or chemically-impaired juveniles being admitted into detention and their need for specialized supervision.

(e) Intoxicated or chemically-impaired individuals who have been medically cleared for admission should be placed under medical isolation in accordance with §343.338 of this chapter.

(f) A juvenile who has been taken into custody by law enforcement and presented for detention at a secure pre-adjudication detention facility shall:

(1) not be left unsupervised; and

(2) be admitted into detention immediately but no later than six (6) hours from the time of entry.

§343.402. Intake Assessment Period.

(a) Residents shall be assigned to the general program as soon as possible after admittance into the facility.

(b) Assessment isolation for periods of time longer than necessary to assess the risks and needs of a resident is prohibited. Assessment isolation shall not exceed 24 hours.

(c) If a resident is confined in his or her room at admission for assessment purposes, juvenile supervision officers shall document the assessment of the resident during this 24-hour period and retain this documentation in the resident's file.

(d) A juvenile supervision officer shall personally observe and record the behavior of a resident during the assessment period at random intervals not to exceed fifteen (15) minutes.

§343.404. Mental Health Screening and Referral.

(a) Mental Health Screening. The standard screening instrument shall be administered to each resident that is admitted into detention within 48 hours.

(b) Positive screening and mental health referral. A resident who scores a positive screening on the standard screening instrument shall be:

(1) administered a secondary screening to assist in clarifying the resident's need for mental health intervention; or

(A) If the secondary screening confirms the positive screening and that mental health intervention is warranted, then a referral shall be made to a mental health professional or licensed physician within 48 hours.

(B) If the secondary screening substantiates that the initial positive screening was false, then no further mental health intervention is required.

(2) referred to a qualified mental health professional for consultation to determine if further intervention is warranted.

(A) The facility shall maintain documentation of the consultation in the resident's file.

(B) If the qualified mental health professional recommends that further mental health intervention is needed, then the resident must be referred to a mental health professional or a licensed physician within 48 hours.

(c) Documentation of recommendations or referrals specific to the juvenile's positive screening on the standard screening instrument shall be forwarded to the supervising juvenile probation officer if the juvenile is released at any point during the proceedings initiated in subsection (b)(1) and (2) of this section. If the juvenile's release concludes any further juvenile justice intervention, then the documentation shall be forwarded to the juvenile's parent, legal guardian or custodian.

(d) Documentation of referrals, completed assessments and evaluations, including dates and times, shall be retained in the juvenile's file and forwarded to the supervising juvenile probation officer.

§343.406. Health Screening and Assessment.

(a) Health Screening. A health screening shall be conducted on each resident within 2 hours of admission by either a health care professional or an individual who has received specific training on administering the facility's health screening procedure. The health screening instrument shall include:

(1) mental health problems;

(2) suicide risk assessment in accordance with the facility's suicide prevention plan;

(3) current state of health including:

(A) allergies;

(B) tuberculosis;

(C) other chronic conditions;

(D) sexually transmitted diseases;

(E) other infectious diseases;

(F) history of gynecological problems or pregnancies; and

(G) recent injuries at or near the time of arrest;

(4) current use of medication including type, dosage and prescribing physician;

(5) visual observation of teeth and gums and notation of any obvious dental problems;

(6) vision problems;

(7) drug and alcohol use;

(8) physical or developmental disabilities;

(9) evidence of physical trauma;

(10) a determination of the need for medical detoxification from alcohol or other substances or mental health services; and

(11) the resident's weight.

(b) Referral for Assessment. If the health screening indicates that a resident is in need of further medical evaluation, the resident shall be referred to a health care professional for further assessment within 24 hours, excluding holidays and weekends, from the date and time of the completed screening.

(c) Mandatory Health Assessment. If a resident has not had a health assessment by a health care professional within the last 12 months immediately preceding admission into the facility, the resident shall be given a health assessment by a health care professional within 30 calendar days after admission into the facility.

(d) Communication of Results of Screening and Assessment. The results of the health screening and health assessment shall be communicated to appropriate staff.

(e) Contagious or Infectious Disease. Any finding of the health screening that indicates a significant potential health risk to the staff or residents from a contagious or infectious disease shall be immediately reported to the facility administrator or the acting facility administrator, and the affected resident shall be placed in medical isolation until proper medical clearance is obtained.

§343.408. Personal Hygiene.

Residents shall be required to surrender their clothing and to shower upon admission into the facility.

§343.410. Personal Property.

A resident's personal property shall be collected, inventoried, and securely stored while the resident is housed in the facility. Documentation that is signed by the resident and the juvenile supervision officer shall be maintained in the resident's file.

§343.412. Orientation.

(a) Each resident shall be provided a verbal orientation within 12 hours of admission into the facility.

(b) The verbal orientation shall include an explanation of the facility's:

(1) procedures to access health care and services available;

(2) program rules with corresponding and maximum disciplinary sanctions;

(3) grievance policies and procedures;

(4) procedures to access mental health care and services available; and

(5) information required by the Prison Rape Elimination Act of 2003 including:

(A) prevention and intervention;

(B) self-protection;

(C) reporting sexual abuse and assault; and

(D) treatment and counseling;

(6) information regarding the reporting of suspected abuse, neglect or exploitation of a child in a juvenile justice facility; and

(7) policy that states the resident is ensured the right of confidentiality with regard to the items included in subsection (b)(3), (5) and (6) of this section and will not face reprisal for participating in the procedures included in these items.

(c) If the resident is not sufficiently fluent in English, arrangements shall be made to provide the resident with an orientation in the resident's primary language within 48 hours of admission.

(d) When a literacy problem prevents a resident from understanding written rules, a staff member or translator shall assist the resident within 48 hours of admission.

(e) Each resident shall be provided a written copy of the orientation materials upon completion of the orientation process.

§343.414. Behavioral Screening.

Prior to placing a resident into a housing unit, the resident shall be screened for potential vulnerabilities or tendencies of acting out with sexually aggressive or assaultive behavior. Housing assignments shall be made accordingly.

§343.416. Classification Plan.

All facilities with more than 1 housing unit shall have a classification plan that takes, at least, the following into account:

(1) age;

(2) gender;

(3) offense;

(4) behavior; and

(5) any other special conditions.

§343.418. Admission Records.

The facility shall have the following information which shall be obtained at the time the resident is admitted into the facility:

(1) date and time of entry;

(2) date and time of admission;

(3) name;

(4) nicknames and aliases;

(5) social security number;

(6) current address;

(7) detention criteria as required by the §53.02(b) of the Texas Family Code;

(8) referring offense;

(9) name of attorney;

(10) name, title, and signature of delivering individual;

(11) gender;

(12) race;

(13) date of birth;

(14) place of birth;

(15) citizenship;

(16) current education level;

(17) last school attended;

(18) name, relationship, address, and phone number of parents, legal guardians, or custodians; and

(19) primary language of the resident and the resident's parent, legal guardian or custodian.

§343.420. Format and Maintenance of Records.

(a) Resident records shall be maintained in a uniform format for identifying and separating files.

(b) Each facility shall have written policies and procedures to ensure the confidentiality of resident files.

§343.422. Content of Resident Records.

Each resident's record shall include the following:

(1) the offense narrative, arrest warrant or directive to apprehend;

(2) the inventory of cash and property surrendered;

(3) the list of approved visitors;

(4) the name of the assigned probation officer;

(5) the behavioral record, including any special incidents, discipline, or grievances;

(6) the referrals to other agencies; and

(7) the final release or transfer report.

§343.424. Housing Records.

For each housing unit in the facility, the following documentation shall be maintained:

(1) a daily chronological log or electronic record documenting the resident's or housing unit's activity that identifies the juvenile supervision officers supervising the residents;

(2) a daily report of admissions and releases; and

(3) a population roster compiled as of 5:00 a.m. each day that shall include at a minimum:

(A) the date and time the roster was compiled;

(B) the name of all residents in the facility;

(C) the gender of all residents in the facility;

(D) the housing assignment location (e.g., the location where the resident sleeps) of all residents in the facility; and

(E) the numerical total of the resident population for each day.

§343.426. Release Procedures.

Prior to the release of a resident from the facility, the authorized officer shall:

(1) verify the identity of the person receiving custody;

(2) verify the release authorization documents;

(3) secure a signed release by the individual receiving the resident's personal property;

(4) provide information to a parent, legal guardian or custodian regarding:

(A) all medication prescribed while the resident was in the facility that the resident is currently taking, and the name and contact information of the prescribing physician;

(B) any pending medical, mental health, or dental appointments; and

(C) any present concerns regarding the resident; and

(5) secure a receipt signed by person receiving custody.

§343.428. Resident Supervision.

A juvenile supervision officer may provide resident supervision if they:

(1) are currently certified as a juvenile supervision officer; or

(2) have been employed by the facility less than 180 calendar days;

(A) have passed the competency evaluation exam as detailed in Chapter 344 of this title; and

(B) have completed a minimum of 40 hours of training, which shall include the mandatory topics as outlined in Chapter 344 of this title, as well as certification in CPR, first aid, and a physical restraint technique approved by the Commission.

§343.430. Minimum Facility Supervision.

At least two (2) juvenile supervision officers shall be on duty at any time the facility has a resident. At least 1 of the officers shall be certified.

§343.432. Gender Supervision Requirement.

(a) If residents of both genders are housed within the facility, juvenile supervision officers of both genders shall be on duty and available to the residents for every shift.

(b) A juvenile supervision officer of one gender shall be prohibited from supervising and visually observing a resident of the opposite gender during showers, physical searches (i.e., strip searches), disrobing of residents (suicidal or not) or when personal hygiene practice (i.e., onset of menstrual cycle, etc.) requires the presence of a juvenile supervision officer of the same gender.

(c) Juvenile supervision officers of one gender shall be the sole supervisors of residents of the same gender during showers, physical searches, pat downs, disrobing of suicidal youth, or during other times in which personal hygiene practices or needs would require the presence of a juvenile supervision officer of the same gender.

§343.434. Facility-Wide Ratio.

The facility-wide juvenile supervision officer-to-resident ratio shall not be less than:

(1) one (1) juvenile supervision officer to every 8 residents during program hours; and

(2) one (1) juvenile supervision officer to every eighteen residents during non-program hours.

§343.436. Supervision Ratio--SOHU.

In a single occupancy housing unit (SOHU), the juvenile supervision officer-to-resident ratio shall not be less than:

(1) one (1) juvenile supervision officer to every twelve residents during program hours; and

(2) one (1) juvenile supervision officer to every 24 residents during non-program hours.

§343.438. Level of Supervision--SOHU.

(a) Program Hours. While residents are located in a single occupancy housing unit, they shall be in constant physical presence of a juvenile supervision officer unless they are placed in their individual sleeping quarters during shift change, in which case, a juvenile supervision officer shall observe and document each resident's behavior at random intervals not to exceed 15 minutes.

(b) Non-Program Hours. During non-program hours, in a single occupancy housing unit, a juvenile supervision officer shall visually observe each resident at random intervals not to exceed 15 minutes.

(c) Juvenile supervision officers shall document each visual observation made. The documentation shall include the time of the observation and generally describe the resident's behavior.

§343.440. Supervision Ratio--MOHU.

Multiple occupancy housing units (MOHU) shall maintain a juvenile supervision officer to resident ratio of no less than one juvenile supervision officer to every eight residents in the housing unit.

§343.442. Level of Supervision--MOHU.

(a) For multiple occupancy housing units designed and operated after June 5, 2001, during program and non-program hours, residents, while physically located in a multiple occupancy housing unit, shall be under the constant visual observation of a juvenile supervision officer.

(b) If juvenile supervision officers supervise residents behind an architectural barrier, the barrier shall provide a complete and unobstructed view of the entire multiple occupancy housing unit. The barrier, with or without the assistance of an electronic device, shall allow for constant auditory monitoring of the unit.

(c) Juvenile supervision officers shall document general observations of dorm activity at intervals not to exceed 30 minutes.

§343.444. Supervision On and Off Premises of Facility.

(a) On-Premises Supervision. Subject to §343.436 of this chapter, residents participating in any programming or activities on the facility premises, but outside of a single or multiple occupancy housing unit, shall be in the constant physical presence of a juvenile supervision officer at all times.

(b) Required Ratio. There shall be at least one (1) juvenile supervision officer to every twelve (12) residents participating in the program or activity.

(c) Off-Premises Supervision. A facility shall have written policies and procedures that establish specific resident supervision practices for residents allowed to temporarily leave the secure confines of the facility or the facility's secure grounds. The policies and procedures shall minimally include:

(1) designations of which staff may supervise youth off-premises;

(2) gender-specific requirements;

(3) staff-to-resident ratios when more than one resident is involved;

(4) personnel authorized to use approved restraint practices; and

(5) staff training requirements.

(d) The established policies and procedures shall be written to adequately provide an appropriate level of protection for the public and involved staff and residents.

(e) Exceptions. This standard does not apply to furlough and formal discharge.

(f) If a juvenile probation officer transports a resident off the facility premises, the juvenile probation officer must be currently certified in CPR, First Aid and, if authorized to use, a Commission-approved personal restraint technique.

§343.446. Exceptions to General Levels of Supervision.

A resident shall be in the constant physical presence of a juvenile supervision officer with exception of the following:

(1) Small Groups. No more than three (3) residents may be supervised by a professional when the professional is working with the residents in a capacity that relates to the professional's licensure, certification, professional training or education.

(2) Small Therapeutic Groups. A juvenile supervision officer shall provide constant visual supervision of any small group between four (4) and eight (8) residents when those residents are working with a licensed or certified mental health professional as defined by §343.100(28) of this chapter.

(3) Visitation. Private visitation between one (1) resident and an attorney, authorized visitor, or clergy does not require the constant physical presence of a juvenile supervision officer.

§343.448. Primary Control Room.

A juvenile supervision officer stationed in and assigned to the facility's primary control room(s) shall not count toward meeting any required supervision ratios, the facility-wide ratio or the minimum requirements under §343.430 of this chapter.

§343.450. Single Occupancy Housing Units--SOHU.

(a) Single occupancy housing units shall be constructed to contain no more than 24 beds in each housing unit.

(b) Individual resident sleeping quarters shall be utilized as single occupancy only; and, at no time, may more than one (1) resident be placed in an individual resident sleeping quarter.

(c) Individual resident sleeping quarters shall contain a bed above floor level.

§343.452. Spatial Requirements--SOHU.

(a) Individual resident sleeping quarters shall have a minimum ceiling height of 7.5 feet.

(b) Individual resident sleeping quarters shall have a minimum of 60 square feet of floor space.

§343.454. Shower Facilities--SOHU.

All single occupancy housing units shall contain at least one (1) operable shower with hot and cold running water for every ten (10) beds in the housing unit.

§343.456. Toilet Facilities--SOHU.

All single occupancy housing units shall contain at least one (1) operable toilet above floor level for every twelve (12) beds in male housing units and one (1) for every eight (8) beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one (1) toilet for every six (6) beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.458. Washbasin Requirements--SOHU.

All single occupancy housing units constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.460. Drinking Fountain--SOHU.

All single occupancy housing units shall contain a drinking fountain.

§343.462. Pre-Assignment Screening Process--MOHU.

Residents shall not be admitted into multiple occupancy housing units directly from the intake process. Classification, screening, and behavioral observation shall occur for at least 72 hours before the decision is made to admit the resident into a multiple occupancy housing unit.

§343.464. Administrative Approval--MOHU.

The placement of any resident into a multiple occupancy housing unit shall be approved by the facility administrator or the acting facility administrator.

§343.468. Classification Plan--MOHU.

Facilities with multiple occupancy housing units shall have a written classification plan that determines how residents are grouped in housing units. Residents shall, at a minimum, be classified for grouping by age and gender.

§343.470. Eligibility Criteria--MOHU.

(a) A formalized (e.g., written) and objective (e.g., scored and weighted) classification assessment shall be completed prior to a resident being assigned to a MOHU. The classification assessment process shall minimally include a review and weighting of the following criteria:

(1) Physical health--A review of all available health documentation in the facility staffs' possession with an emphasis on assessing any diagnosed or suspected infectious or contagious diseases;

(2) Mental health--A review of all available mental health documentation in the facility staffs' possession with an emphasis on assessing mental health or mental illness diagnoses that could be exacerbated by, or that would not be conducive to, multiple occupancy housing settings;

(3) Sexual behavior--An assessment of the resident's potential to be sexually abused by other residents and his or her potential to be sexually abusive;

(4) Aggressive or assaultive behaviors--An assessment of resident's history of, or propensity for, aggressive (both verbal and physical) and assaultive behaviors. This assessment shall minimally include a review of the resident's formal referral history (both alleged and disposed charges) as well as institutional behavior records;

(5) Susceptibility to acts of peer abuse, harassment and exploitation--This shall minimally include an assessment of a resident's physical stature, emotional maturity, enemies of record, and social functioning information;

(6) Institutional behavior or discipline records--This assessment shall include a review of a resident's behavior records for the current term of detention as well as any available behavior records from previous institutional custody periods provided by the assessing jurisdiction; and

(7) Special needs or circumstances that may compromise the resident's, or other MOHU residents', physical safety and successful service delivery processes.

(b) The completed classification assessment document shall include an objective assessment score or recommendation for or against a MOHU assignment, the date the assessment process was completed, the signature of the person completing the assessment, and the signature of the supervisory level staff that reviewed and approved the assessment.

§343.472. Multiple Occupancy Housing Units--MOHU.

(a) The utilization of multiple occupancy housing units shall have prior written approval and authorization from the governing board of the facility.

(b) Sections 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480 and 343.482 of this chapter apply only to multiple occupancy housing units designed and operating as such on or after June 5, 2001.

(c) Multiple occupancy housing units shall be designed to contain no more than eight (8) beds in each housing unit.

(d) The capacity of multiple occupancy housing units shall not exceed 25 percent of the design capacity of the facility.

(e) Multiple occupancy housing units shall have one (1) bed above floor level for every resident assigned to the unit.

(f) Multiple occupancy housing units shall contain residents of the same gender.

§343.474. Spatial Requirements--MOHU.

(a) Multiple occupancy housing units shall have a minimum ceiling height of 7.5 feet.

(b) Multiple occupancy housing units shall have a minimum of 35 square feet of unencumbered floor space per bed in the housing unit.

§343.476. Shower Facilities--MOHU.

All multiple occupancy housing units shall contain at least one (1) operable shower with hot and cold running water for every eight (8) beds in the housing unit.

§343.478. Toilet Facilities--MOHU.

All multiple occupancy housing units shall contain at least one (1) operable toilet above floor level for every four (4) beds in the housing unit.

§343.480. Washbasin Requirements--MOHU.

All multiple occupancy housing units shall contain at least one (1) washbasin with hot and cold running water.

§343.482. Drinking Fountain--MOHU.

All multiple occupancy housing units shall contain a drinking fountain.

§343.484. Exercise and Common Activity Areas.

(a) Exercise Area. The facility shall provide space for an exercise area.

(b) Common Activity Area. The facility's total common activity area shall encompass no less than 100 square feet of floor space per resident.

§343.486. Program Hours.

Each facility shall have a daily written program schedule outlining the stated activities during program hours.

(1) Each resident shall be provided a minimum of ten (10) hours of structured and unstructured activities.

(2) Exceptions. Residents who are in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation may receive modification to their respective program day.

(3) The facility shall maintain documentation of any program schedule deviation or modification.

§343.488. Educational Program.

(a) The facility administrator shall ensure that there is an educational program that requires all residents to participate. The educational program provided shall be administered in accordance with rules adopted by the Texas Education Agency (TEA).

(b) The facility administrator shall ensure that the education provider has access to residents so that the educational program is afforded to all residents, in accordance with rules adopted by the Texas Education Agency (TEA).

§343.489. Educational Curriculum.

Students shall be provided coursework that is aligned with the Texas Essential Knowledge and Skills, in accordance with rules adopted by the Texas Education Agency (TEA).

§343.490. Instructional Days.

The facility administrator shall ensure that the educational program provides for at least 180 days of instruction unless a waiver has been granted by the Texas Education Agency for fewer days or the number of educational days coincides with the local school district calendar.

§343.491. Special Education.

(a) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities are provided a free and appropriate public education (FAPE) as determined by the Admission, Review and Dismissal (ARD) committee in order to meet the individual educational needs of the student as defined by federal and state laws.

(b) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities have available an instructional day commensurate with that of students without disabilities, in accordance with requirements contained in 19 TAC §89.1075(d).

(c) The facility administrator or designee shall send notification of a student placement in a residential facility to the LEA as required by §29.012 of the Texas Education Code and shall retain documentation of this notice.

§343.492. Educational Space.

The facility administrator shall ensure that educational space is adequate to meet the instructional requirements for each resident.

§343.493. Educational Staff Safety.

All permanent educational staff, excluding temporary substitutes, shall receive a facility orientation prior to performing instructional duties. Orientation shall include:

(1) security procedures;

(2) emergency procedures;

(3) behavior management system and prohibited sanctions; and

(4) reporting abuse, neglect and exploitation.

§343.494. Supervision During Educational Program.

Educational staff shall not be counted in staff-to-resident ratios.

§343.496. Reading Materials.

Age-appropriate reading materials shall be available to all residents.

§343.498. Recreation and Exercise.

(a) Supplies. Recreational equipment and supplies shall be provided to the residents.

(b) The recreational schedule shall offer the following programming:

(1) Large Muscle Exercise. At least one (1) hour of large muscle exercise shall be scheduled each day.

(2) Open Recreational Activity. At least one (1) hour of open recreational activity shall be scheduled each day.

(c) Exceptions. A resident's recreational schedule may be altered under the following conditions:

(1) participation by a resident is contra-indicated for medical reasons;

(2) a resident is in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation;

(3) the resident has a scheduled appointment;

(4) extenuating circumstances exist that impede the recreational schedule; or

(5) the resident presents an imminent danger to self or others. Utilization of this provision shall require the written approval of the facility administrator or the acting facility administrator.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER D. SECURE POST-ADJUDICATION CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, 343.712

These standards are proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.600. Required Pre-Admission Records.

Prior to a resident's admission, the facility shall receive the following from the referring agency:

(1) a completed State of Texas Common Application Form, except when the facility is operated by the referring agency;

(2) a psychological evaluation, or behavioral health assessment (as defined in the CRM), completed within 365 calendar days prior to the resident's admission date;

(3) a signed disposition order or TYC commitment order;

(4) a current immunization record;

(5) a medical examination that was completed within 30 calendar days prior to the resident's admission date;

(6) documentation that a tuberculosis test was administered and results were received no more than 365 calendar days prior to admission;

(7) a dental evaluation that was completed within 30 calendar days prior to the resident's admission date;

(8) services needed for the disabled;

(9) primary language of the resident and the resident's parent, legal guardian or custodian; and

(10) school records.

§343.602. Intake and Admission.

(a) Pre-Admission Assessment. Each facility shall have written policies and procedures addressing the admission of juveniles who are in need of emergency medical care due to injury, illness or intoxication or who are in need of mental health services.

(1) Anyone presented for admission into the facility and is in need of emergency medical care due to injury, illness or intoxication or is in need of mental health intervention shall not be admitted into the facility.

(2) The referring person shall be directed to a health care facility to have the individual evaluated and treated.

(3) Subsequent admission into the facility is contingent upon written medical clearance provided by a health care or mental health professional.

(b) Intoxicated or Chemically-Impaired Individuals. Each facility shall have written policies and procedures addressing intoxicated or chemically-impaired juveniles being admitted into the facility and their need for specialized supervision.

(c) Intoxicated or chemically-impaired individuals who have been medically cleared for admission should be placed under medical isolation in accordance with §343.338 of this chapter.

§343.604. Health Screening and Assessment.

(a) Health Screening. A health screening shall be conducted on each resident within two (2) hours of admission by either a health care professional or an individual who has received specific training on administering the facility's health screening procedure. The health screening instrument shall include:

(1) mental health problems;

(2) suicide risk in accordance with the facility's suicide prevention plan's screening methodology;

(3) current state of health including:

(A) allergies;

(B) tuberculosis;

(C) other chronic conditions;

(D) sexually transmitted diseases;

(E) other infectious diseases; and

(F) history of gynecological problems or pregnancies;

(4) current use of medication including type, dosage and prescribing physician;

(5) visual observation of teeth and gums and notation of any obvious dental problems;

(6) vision problems;

(7) drug and alcohol use;

(8) physical and developmental disabilities;

(9) evidence of physical trauma; and

(10) a determination of the need for medical detoxification from alcohol or other substances or mental health intervention.

(b) Referral for Assessment. If the health screening indicates that a resident is in need of further medical evaluation, the resident shall be referred to a health care professional for further assessment within 24 hours, excluding holidays and weekends, from the date and time of the completed screening.

(c) Communication of Results of Screening and Assessment. The results of the health screening and health assessment shall be communicated to appropriate staff.

(d) Contagious or Infectious Disease. Any finding of the health screening that indicates a significant potential health risk to the staff or residents from a contagious or infectious disease shall be reported immediately to the facility administrator or the acting facility administrator, and the affected resident shall be placed in medical isolation until proper medical clearance is obtained.

(e) Intra-Jurisdictional Custodial Transfer. For intra-jurisdictional custodial transfer of residents, the only items required for the health screening at admission into a post-adjudication secure correctional facility are items enumerated in subsection (a)(2) and (9) of this section.

§343.606. Orientation.

(a) Each resident shall be provided a verbal orientation within twelve (12) hours of admission into the facility.

(b) The verbal orientation shall include an explanation of the facility's:

(1) procedures to access health care and services available;

(2) program rules with corresponding and maximum disciplinary sanctions;

(3) grievance policies and procedures;

(4) procedures to access mental health care and services available; and

(5) information required by the Prison Rape Elimination Act of 2003 including:

(A) prevention and intervention;

(B) self-protection;

(C) reporting sexual abuse and assault; and

(D) treatment and counseling;

(6) information regarding the reporting of suspected abuse, neglect or exploitation of a child in a juvenile justice facility; and

(7) information stating that the resident is ensured the right of confidentiality with regard to the items included in paragraphs (b)(3),

(5), and (6) of this subsection and will not face reprisal for participating in the procedures included in these items.

(c) If the resident is not sufficiently fluent in English, arrangements shall be made to provide the resident with an orientation in the resident's primary language within 48 hours of admission.

(d) When a literacy problem prevents a resident from understanding written rules, a staff member or translator shall assist the resident within 48 hours.

(e) Each resident shall be provided a written copy of the orientation materials upon completion of the orientation process.

§343.608. Classification Plan.

All facilities with more than one (1) housing unit shall have a classification plan that takes into account at least the following:

(1) age;

(2) gender;

(3) offense;

(4) behavior; and

(5) any other special conditions.

§343.610. Classification Plan--Segregation.

The classification plan shall require that residents assigned to progressive sanctions level 5 and below be physically segregated from residents assigned to progressive sanctions levels 6 and 7.

§343.612. Admission Records.

The facility shall obtain and record the following information at the time the resident is admitted into the facility:

(1) date and time of admission;

(2) name;

(3) nicknames and aliases;

(4) social security number;

(5) last known address;

(6) adjudicated offense;

(7) name of attorney;

(8) name, title, and signature of delivering individual;

(9) gender;

(10) race;

(11) date of birth;

(12) citizenship;

(13) place of birth;

(14) name, relationship, address, and phone number of parents, legal guardians, or custodians; and

(15) primary language of resident and resident's parent, legal guardian, or custodian.

§343.614. Format and Maintenance of Records.

(a) Resident records shall be maintained in a uniform format for identifying and separating files.

(b) Each facility shall have written policies and procedures to ensure the confidentiality of resident files.

§343.616. Content of Resident Records.

Each resident's record shall include the following:

(1) delinquent history;

(2) inventory of cash and property surrendered;

(3) list of approved visitors;

(4) name of the assigned probation officer;

(5) behavioral record, including any special incidents, discipline, or grievances;

(6) progress reports; and

(7) final release and transfer report.

§343.618. Housing Records.

For each housing unit in the facility, the following documentation shall be maintained:

(1) a daily chronological log or electronic record documenting the resident's or housing unit's activity that identifies the juvenile supervision officers supervising the residents;

(2) a daily report of admissions and releases; and

(3) a population roster compiled as of 5:00 a.m. each day that shall include, at a minimum:

(A) the date and time the roster was compiled;

(B) the name of all residents in the facility;

(C) the gender of all residents in the facility;

(D) the housing assignment location (i.e., the location where the resident sleeps) of all residents in the facility; and

(E) the numerical total of the resident population for each day.

§343.620. Release Procedures.

Prior to the release of each resident from the facility, the authorized officer shall:

(1) verify the identity of the person receiving custody;

(2) verify the release authorization documents;

(3) secure a signed release by the individual receiving the resident's personal property;

(4) provide information to a parent, legal guardian or custodian regarding:

(A) all medication prescribed while the resident was in the facility that the resident is currently taking, and the name and contact information of the prescribing physician;

(B) any pending medical, mental health, or dental appointments; and

(C) any present concerns regarding the resident;

(5) secure a receipt signed by person receiving custody.

§343.622. Resident Supervision.

A juvenile supervision officer may provide resident supervision if they:

(1) are currently certified as a juvenile supervision officer; or

(2) have been employed by the facility less than 180 calendar days, and:

(A) have passed the competency evaluation exam as detailed in Chapter 344 of this title; and

(B) have completed a minimum of 40 hours of training, which shall include the mandatory topics as outlined in Chapter 344 of

this title as well as certification in CPR, first aid, and a physical restraint technique approved by the Commission.

§343.624. Minimum Facility Supervision.

At least two (2) juvenile supervision officers shall be on duty at any time the facility has a resident. At least one (1) of the officers shall be certified.

§343.626. Gender Supervision Requirement.

(a) If residents of both genders are housed within the facility, juvenile supervision officers of both genders shall be on duty and available to the residents for every shift.

(b) A juvenile supervision officer of one gender shall be prohibited from supervising and visually observing a resident of the opposite gender during showers, physical searches (i.e., strip searches), disrobing of residents (suicidal or not) or when personal hygiene practice (e.g., onset of menstrual cycle, etc.) requires the presence of a juvenile supervision officer of the same gender.

(c) Juvenile supervision officers of one gender shall be the sole supervisors of residents of the same gender during showers, physical searches, pat downs, disrobing of suicidal youth, or during other times in which personal hygiene practices or needs would require the presence of a juvenile supervision officer of the same gender.

§343.628. Facility-Wide Ratio.

The facility-wide juvenile supervision officer-to-resident ratio shall not be less than:

(1) one (1) juvenile supervision officer to every 8 residents during program hours;

(2) one (1) juvenile supervision officer to every 20 residents during non-program hours; and

(3) one (1) juvenile supervision officer to every 18 residents during non-program hours if a post-adjudication facility is located in the same building as a pre-adjudication facility.

§343.630. Supervision Ratio.

The juvenile supervision officer to resident ratio shall not be less than:

(1) one (1) juvenile supervision officer to every 12 residents during program hours;

(2) one (1) juvenile supervision officer to every 24 residents during non-program hours.

§343.632. Level of Supervision--SOHU.

(a) Program Hours. While residents are located in a single occupancy housing unit, they shall be in constant physical presence of a juvenile supervision officer unless they are placed in their individual sleeping quarters during shift change, in which case, a juvenile supervision officer shall observe and document each resident's behavior at random intervals not to exceed 15 minutes.

(b) Non-Program Hours. During non-program hours, in a single occupancy housing unit, a juvenile supervision officer shall visually observe each resident at random intervals not to exceed 15 minutes.

(c) Juvenile supervision officers shall document each visual observation made. The documentation shall include the time of the observation and generally describe the resident's behavior.

§343.634. Level of Supervision--MOHU.

(a) While physically located in a multiple occupancy housing unit (MOHU), residents shall be under the constant visual observation of a juvenile supervision officer during program and non-program hours.

(b) Juvenile supervision officers shall document general observations of dorm activity at intervals not to exceed 30 minutes.

§343.636. Supervision On and Off Premises of Facility.

(a) On-Premises Supervision. Subject to §343.628 of this chapter, residents participating in any programming or activities on the facility premises, but outside of a single or multiple occupancy housing unit, shall be in the constant physical presence of a juvenile supervision officer at all times.

(b) Required Ratio. There shall be at least one juvenile supervision officer to every twelve residents participating in the program or activity.

(c) Off-Premises Supervision. A facility shall have written policies and procedures that establish specific resident supervision practices for residents allowed to temporarily leave the secure confines of the facility or the facility's secure grounds. The policies and procedures shall minimally include:

(1) applicable staff designations (i.e., which staff may supervise youth off site);

(2) gender-specific requirements;

(3) staff-to-resident ratios when more than one resident is involved;

(4) personnel authorized to use approved restraint practices; and

(5) staff training requirements.

(d) The established policies and procedures shall be written to adequately provide an appropriate level of protection for the public and involved staff and residents.

(e) Exceptions. This standard does not apply to furlough and formal discharge.

§343.638. Exceptions to General Levels of Supervision.

A resident shall be in the constant physical presence of a juvenile supervision officer with exception of the following:

(1) Small Groups. No more than three (3) residents may be supervised by a professional when the professional is working with the residents in a capacity that relates to the professional's licensure, certification, professional training or education.

(2) Small Therapeutic Groups. A juvenile supervision officer shall provide constant visual supervision of any small group between four (4) and eight (8) residents when those residents are working with a licensed or certified mental health professional as defined by §343.100(28) of this chapter.

(3) Visitation. Private visitation between one (1) resident and an attorney, authorized visitor, or clergy does not require the constant physical presence of a juvenile supervision officer.

§343.640. Primary Control Room.

A juvenile supervision officer stationed in and assigned to the facility's primary control room(s) shall not count toward meeting any required supervision ratios, the facility-wide ratio or the minimum requirements under §343.624 of this chapter.

§343.642. Single Occupancy Sleeping Units--SOHU.

(a) Single occupancy housing units shall be constructed to contain no more than 24 beds in each housing unit.

(b) Individual resident sleeping quarters shall be utilized as single occupancy only; and at no time, may more than one (1) resident be placed in an individual resident sleeping quarter.

(c) Individual resident sleeping quarters shall contain a bed above floor level.

§343.644. Spatial Requirements--SOHU.

(a) Individual resident sleeping quarters shall have a minimum ceiling height of 7.5 feet.

(b) Individual resident sleeping quarters shall have a minimum of 60 square feet of floor space.

§343.646. Shower Facilities--SOHU.

All single occupancy housing units shall contain at least one (1) operable shower with hot and cold running water for every ten (10) beds in the housing unit.

§343.648. Toilet Facilities--SOHU.

All single occupancy housing units shall contain at least one (1) operable toilet above floor level for every twelve (12) beds in male housing units and one (1) for every eight (8) beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one (1) toilet for every six (6) beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.650. Washbasin Requirements--SOHU.

All single occupancy housing units constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.652. Drinking Fountain--SOHU.

All single occupancy housing units shall contain a drinking fountain.

§343.654. Multiple Occupancy Housing Units--MOHU.

(a) Multiple occupancy housing units shall be constructed to contain no more than 24 beds in each housing unit.

(b) Multiple occupancy housing units shall have one (1) bed above floor level for every resident assigned to the unit.

(c) Multiple occupancy housing units shall contain residents of the same gender.

(d) If bunk beds are utilized, they shall not exceed two (2) levels.

§343.656. Spatial Requirements--MOHU.

(a) Multiple occupancy housing units shall have a minimum ceiling height of seven and 7.5 feet.

(b) Multiple occupancy housing units shall have a minimum of 35 square feet of unencumbered floor space per bed in the housing unit.

§343.658. Shower Facilities--MOHU.

All multiple occupancy housing units shall contain at least one (1) operable shower with hot and cold running water for every ten (10) beds in the housing unit.

§343.660. Toilet Facilities--MOHU.

All multiple occupancy housing units shall contain at least one (1) operable toilet above floor level for every twelve beds in male housing units and one (1) for every eight (8) beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one (1) toilet for every six (6) beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.662. Washbasin Requirements--MOHU.

All multiple occupancy housing units constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.664. Drinking Fountain--MOHU.

All multiple occupancy housing units shall contain a drinking fountain.

§343.666. Exercise and Day Room Areas.

(a) Exercise Areas. The facility shall provide an area for an indoor and outdoor exercise.

(b) Day Rooms.

(1) Day rooms shall provide a minimum of 35 square feet of space for every resident using the day room at one time, excluding lavatories, showers, and toilets.

(2) Day rooms shall provide sufficient seating and writing surfaces for every resident using the day room at one time.

§343.668. Program Hours.

Each facility shall have a daily written program schedule outlining the stated activities during program hours.

(1) Each resident shall be provided a minimum of ten (10) hours of structured and unstructured activities.

(2) Exceptions. Residents who are in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation may receive modification to their respective program day.

(3) The facility shall maintain documentation of any program schedule deviation or modification.

§343.670. Educational Program.

(a) The facility administrator shall ensure that there is an educational program that requires all residents to participate. The educational program provided shall be administered in accordance with rules adopted by the Texas Education Agency (TEA).

(b) The facility administrator shall ensure that the education provider has access to residents so that the educational program is afforded to all residents, in accordance with rules adopted by the Texas Education Agency (TEA).

§343.671. Educational Curriculum.

Students shall be provided coursework that is aligned with the Texas Essential Knowledge and Skills, in accordance with rules adopted by the Texas Education Agency (TEA).

§343.672. Instructional Days.

The facility administrator shall ensure that the educational program provides for at least 180 days of instruction unless a waiver has been granted by the Texas Education Agency for fewer days or the number of educational days coincides with the local school district calendar.

§343.673. Special Education.

(a) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities are provided a free and appropriate public education (FAPE) as determined by the Admission, Review and Dismissal (ARD) committee in order to meet the individual educational needs of the student as defined by federal and state laws.

(b) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities have available an instructional day commensurate

with that of students without disabilities, in accordance with requirements contained in 19 TAC §89.1075(d).

(c) The facility administrator or designee shall send notification of a student placement in a residential facility to the LEA as required by §29.012 of the Texas Education Code and shall retain documentation of this notice.

§343.674. Educational Space.

The facility administrator shall ensure that educational space is adequate to meet the instructional requirements for each resident.

§343.675. Educational Staff Safety.

All permanent educational staff, excluding temporary substitutes, shall receive a facility orientation prior to performing instructional duties. Orientation shall include:

(1) security procedures;

(2) emergency procedures;

(3) behavior management system and prohibited sanctions; and

(4) reporting abuse, neglect and exploitation.

§343.676. Supervision During Educational Program.

Educational staff shall not be counted in staff-to-resident ratios.

§343.677. Vocational Training Program.

The facility administrator shall ensure that a vocational training program offered to residents, that is not administered by the school and through which no academic credit is gained, is administered by appropriately qualified persons to provide instruction or mentoring in the vocational skills.

§343.678. Reading Materials.

Age-appropriate reading materials shall be available to all residents.

§343.680. Recreation and Exercise.

(a) Supplies. Recreational equipment and supplies shall be provided for use by residents.

(b) The recreational schedule shall offer the following programming:

(1) Large Muscle Exercise. At least one (1) hour of large muscle exercise shall be scheduled each day.

(2) Open Recreational Activity. At least one (1) hour of open recreational activity shall be scheduled each day.

(c) Exceptions. A resident's recreational schedule may be altered under the following conditions:

(1) participation by a resident is contra-indicated for medical reasons;

(2) a resident is in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation;

(3) the resident has a scheduled appointment;

(4) extenuating circumstances exist that impede the recreational schedule; or

(5) the resident presents an imminent danger to self or others. Utilization of this provision shall require the written approval of the facility administrator or the acting facility administrator.

§343.686. Rehabilitative Services.

The social services program shall provide for the availability of:

(1) professional counseling services (individual and group);

(2) substance abuse prevention education; and

(3) HIV/AIDS prevention education.

§343.688. Residential Case Plan.

(a) The initial case plan shall be completed no later than 30 calendar days from the resident's date of placement.

(b) The case plan shall contain written documentation acknowledging that the plan was developed in consultation with the resident, the resident's parent, legal guardian or custodian, and the supervising juvenile probation officer.

(c) The case plan shall contain specific goals for at least the following nine domains:

(1) medical and dental;

(2) safety and security;

(3) recreational;

(4) educational;

(5) mental and behavioral health;

(6) relationship;

(7) socialization;

(8) permanency; and

(9) parent and child participation.

(d) The case plan shall be signed by the resident, the resident's parent, legal guardian or custodian, the facility's designee and the supervising juvenile probation officer.

(e) The date of the facility designee's signature on the case plan shall be the case plan completion date.

(f) The case plan shall be retained in the resident's case file with written documentation verifying that copies were provided to the resident, the resident's parent, legal guardian or custodian and the supervising juvenile probation officer.

§343.690. Residential Case Plan Review.

(a) Case plans shall be reviewed ninety (90) calendar days from the date of completion of the initial case plan or case plan review and every ninety (90) calendar days thereafter.

(b) The case plan review shall contain written documentation acknowledging that the review was conducted in consultation with the resident, the resident's parent, legal guardian or custodian, and the supervising juvenile probation officer.

(c) The case plan review shall discuss the extent of the juvenile's progress towards achieving the goals identified in the previous case plan or case plan review.

(d) The case plan review shall document any newly indentified needs, goals, and interventions for the juvenile and the juvenile's family.

(e) The case plan review shall be signed by the resident, the resident's parent, legal guardian, or custodian, the facility's designee and the supervising juvenile probation officer.

(f) The date of the facility designee's signature on the case plan review shall be the case plan review completion date.

(g) The case plan review shall be retained in the resident's case file with written documentation verifying that copies were provided to the resident, the resident's parent, legal guardian or custodian, and the supervising juvenile probation officer.

§343.700. Physical Training Program.

Sections 343.700 - 343.714 of this chapter apply to those facilities that have a physical training program.

§343.702. Governing Board Approval.

Facilities that utilize a physical training program shall have written authorization from the governing board prior to operation.

§343.704. Pre-Admission Requirements.

Prior to admitting a resident into the facility, the following documentation shall be reviewed by the facility administrator or designee:

(1) a medical release signed and dated by a physician approving the resident's participation in the facility's physical training program;

(2) the physician's acknowledgement of the components of the physical training program; and

(3) a psychological evaluation, or behavioral health assessment (as defined in the CRM), which should indicate in writing the appropriateness for the child's placement at the facility based on the needs and/or limitations of the child (i.e., mental illness, history of abuse, etc.).

§343.706. Physical Training Program Plan.

The facility shall have a written physical training program plan developed in consultation with the facility's health service authority and approved by the governing board. The plan shall include:

(1) a physical fitness screening tool that addresses whether the resident has the physical capability to fully participate in the physical training program. The tool shall be selected or developed by the facility administrator or designee;

(2) a curriculum that addresses the specific types of exercises authorized to be used within the program. The curriculum shall:

(A) define the time limitations of the individual exercises used in the physical training program; and

(B) define the set number of repetitions of each exercise per session;

(3) specific minimal criteria to determine when outdoor weather conditions are too extreme or dangerous for physical training. The criteria shall address scheduling changes when necessary to ensure the safety of residents (e.g., seasonal scheduling changes to accommodate for weather patterns);

(4) adjustments for increased dietary allowances in the residents' menu plan to accommodate the need for modified caloric intake and hydration; and

(5) protocols for removal from the program if the resident becomes unfit to participate in the physical training program due to medical or mental health reasons.

§343.708. Injury and Illness.

If the resident is, at any time, deemed unfit to participate in the physical training program due to medical reasons, to return the resident to the program, the facility must obtain a written release signed by a physician indicating that the resident is fit to resume program activities.

§343.710. Disciplinary Sanctions.

The facility shall have written policies and procedures, including guidelines, parameters, and limitations, on the types of physical activity that may be utilized for discipline or refocusing purposes (e.g., physical activities used to discipline for non-compliant behavior or as a substitute for write-ups or disciplinary seclusion).

§343.712. Physical Fitness Screening Tool.

(a) The resident shall not participate in the physical training program until the initial physical fitness screening tool has been completed and evaluated.

(b) Every 30 calendar days, the facility shall administer the physical fitness screening tool to re-evaluate the resident's ability to participate in the physical training program.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

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Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, 343.818

These standards are proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.800. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless otherwise expressly defined in the chapter:

(1) Approved Personal Restraint Technique--A professionally trained, curriculum-based, and competency-based restraint technique that uses a person's physical exertion to completely or partially constrain another person's body movement without the use of mechanical restraints. Personal restraint techniques shall first be approved for use by the Commission.

(2) Approved Mechanical Restraint Devices--A professionally manufactured and commercially available mechanical device designed to aid in the restriction of a person's bodily movement. Mechanical restraint devices shall first be approved by the Commission. The following are Commission-approved mechanical restraint devices:

(A) Ankle Cuffs--A metal, cloth, or leather band designed to be fastened around the ankle to restrain free movement of the legs;

(B) Anklets--A cloth or leather band designed to be fastened around the ankle or leg;

(C) Handcuffs--Metal devices designed to be fastened around the wrist to restrain free movement of the hands and arms;

(D) Plastic Cuffs--Plastic devices designed to be fastened around the wrists or legs to restrain free movement of hands, arms or legs;

(E) Restraint Bed--A professionally manufactured and commercially available bed, or integrated bed attachment(s), specifically designed to facilitate safe human restraint applications;

(F) Restraint Chair--A professionally manufactured and commercially available restraint apparatus specifically designed for safe human restraint. The device's design facilitates the almost complete immobilization of a subject in an upright sitting position by restricting the subject's extremities, upper leg area, and torso through the application of soft-restraints. The apparatus may be fixed or wheeled for re-location;

(G) Waist Belt--A cloth, leather, or metal band designed to be fastened around the waist used to secure the arms to the sides or front of the body; and

(H) Wristlets--A cloth or leather band designed to be fastened around the wrist, which may be secured to a waist belt or used in a non-ambulatory mechanical restraint.

(3) Chemical Restraint--The application of a chemical agent on a resident or residents.

(4) Four-Point Restraint--The use of approved mechanical restraint devices applied to each of a resident's wrists and ankles to secure a resident in a supine position to a restraint bed.

(5) Mechanical Restraint--The application of an approved mechanical restraint device which restricts or aids in the restriction of the movement of the whole or a portion of an individual's body to control physical activity.

(6) Non-Ambulatory Mechanical Restraint--A method of prohibiting a resident's ability to stand upright and walk with the use of a combination of approved mechanical restraint devices, cuffing techniques and the subject's body positioning. The four-point restraint and a restraint chair are examples of acceptable non-ambulatory mechanical restraints.

(7) Personal Restraint--The application of physical force alone, restricting the free movement of the whole or a portion of an individual's body to control physical activity.

(8) Physical Escort--Touching or holding a resident with a minimum use of force for the purpose of directing the resident's movement from one place to another. A physical escort is not considered a personal restraint.

(9) Protective Devices--Professionally manufactured devices used for the protection of residents or staff that do not restrict the movement of a resident. Protective devices are not considered mechanical restraint devices.

(10) Restraint--The application of an approved personal restraint technique, an approved mechanical restraint device, or a chemical restraint to an individual so as to restrict the individual's freedom of movement or to modify the individual's behavior.

(11) Riot--A situation in which three (3) or more persons in the facility intentionally participate in conduct that constitutes a clear and present danger to persons or property and substantially obstructs the performance of facility operations or a program therein. Rebellion is a form of riot.

(12) Soft Restraints--Non-metallic wristlets and anklets used as stand-alone restraint devices or in conjunction with a restraint bed or restraint chair. These devices are designed to reduce the incidence of skin, nerve, and muscle, damage to the restrained subject's extremities.

§343.802. Requirements.

(a) Restraints shall only be used by juvenile supervision and probation officers.

(b) Prior to participating in any restraint, juvenile probation officers and juvenile supervision officers shall be trained in the use of the facility's specific verbal de-escalation policies, procedures, and practices.

(c) Prior to participating in a physical restraint, juvenile probation officers and juvenile supervision officers shall have received training and demonstrated competency in the Commission-approved restraint used by the facility.

(d) Restraints shall only be used in instances of an imminent threat of self injury, injury to others or serious property damage, or to prevent escapes.

(e) Restraints shall only be used as a last resort.

(f) Only the amount of force and type of restraint necessary to control the situation shall be used.

(g) Restraints shall be implemented in such a way as to protect the health and safety of the resident and others.

(h) Restraints shall be terminated as soon as the resident's behavior indicates that the imminent threat of self injury, injury to others, serious property damage, or the threat of escape has subsided.

§343.804. Prohibitions.

Restraints that employ a technique listed below are prohibited:

(1) restraints used for punishment, discipline, retaliation, harassment, compliance, intimidation, or as a substitute for an appropriate disciplinary seclusion;

(2) restraints that deprive the resident of basic human necessities, including restroom privileges, water, food, and clothing;

(3) restraints that are intended to inflict pain;

(4) restraints that place a resident in a prone or supine position with sustained or excessive pressure on the back, chest, or torso;

(5) restraints that place a resident in a prone or supine position with pressure on the neck or head;

(6) restraints that obstruct the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose;

(7) restraints that interfere with the resident's ability to communicate;

(8) restraints that obstruct the view of the resident's face;

(9) any technique that does not require the monitoring of the resident's respiration and other signs of physical distress during the restraint; and

(10) percussive or electrical shocking devices.

§343.806. Documentation.

Except as required by §343.818 of this chapter, all restraints shall be fully documented and maintained. Written documentation regarding the use of restraints shall, at a minimum, require:

(1) the name of the resident;

(2) the staff member(s) name and title(s) who administered the restraint;

(3) the date of the restraint;

(4) the duration of each type of restraint, including notation of the time each type of restraint began and ended;

(5) the location of the restraint;

(6) the description of the preceding activities;

(7) the behavior which prompted the initial and the continued restraint of the resident;

(8) the type of restraint(s) applied;

(A) the specific type of personal restraint hold applied;

(B) the any type of mechanical restraint device(s) applied; and

(C) any type of chemical restraint(s) utilized;

(9) de-escalation efforts as well as all restraint alternatives attempted; and

(10) whether or not any injury occurred during the restraint and the description of the injury.

§343.808. Personal Restraint.

In addition to the requirements found in §§343.802, 343.804, and 343.806 of this chapter, the use of personal restraints shall be governed by following criteria:

(1) Personal restraints shall be administered in a manner specific, or consistent, to the approved personal restraint technique adopted by the facility.

(2) Juvenile supervision and probation officers shall be retrained in the approved personal restraint technique at least every 365 calendar days.

§343.810. Mechanical Restraint.

(a) Requirements.

(1) Only the approved mechanical restraint devices shall be used by a facility.

(2) Mechanical restraint devices shall only be used in a manner consistent with their intended use.

(3) All mechanical restraint devices shall be inspected at least every 365 calendar days, with all faulty or malfunctioning devices restricted from use until they are repaired or replaced.

(4) Mechanical restraints may be used when moving a resident from point to point within the facility. The mechanical restraint shall be terminated upon completion of the resident's relocation.

(b) Prohibitions.

(1) Approved mechanical restraint devices shall not be altered from the manufacturer's design.

(2) A resident shall not be placed in a prone position while restrained in any mechanical restraint for a period of time longer than necessary to apply the restraint device.

(3) A mechanical restraint shall not secure a resident in a prone or supine or lateral position with his or her arms and hands behind the resident's back and secured to the resident's legs.

(4) Approved mechanical restraint devices shall not be secured so tightly as to interfere with circulation or so loosely as to cause chafing of the skin.

(5) Approved mechanical restraint devices shall not be secured to a stationary object, except when complete immobilization is required by use of a four-point restraint or a restraint chair.

(6) A resident in an approved mechanical restraint device shall not participate in any physical activity.

(7) Plastic cuffs shall only be used in emergency situations.

§343.812. Non-Ambulatory Mechanical Restraints.

(a) Non-ambulatory mechanical restraints shall only be used in response to a resident's overt behavior specific to self injury and only when other less restrictive interventions, or other forms of physical restraint, have been deemed to be inappropriate or ineffective.

(b) The initial use of non-ambulatory mechanical restraints shall receive incident-specific authorization from the facility administrator or the acting facility administrator. Standing orders authorizing non-ambulatory mechanical restraints are prohibited.

(c) Non-ambulatory mechanical restraints shall be conducted in an area or room which is not visible to other residents but in a location that is readily accessible to health care professionals or specially trained staff with supervisory responsibilities specific to the oversight of the non-ambulatory mechanical restraints.

(d) Rooms or cells with fixed or static non-ambulatory mechanical restraint fixtures, mechanisms, etc. (e.g. anchoring points or devices) shall not be used to house residents not being restrained in a non-ambulatory mechanical restraint unless they are being provided constant supervision.

(e) Non-ambulatory mechanical restraints shall be restricted to only standards-compliant restraint beds, restraint chairs and soft restraint devices.

(f) A written recommendation from a health care professional or a mental health professional is required in order for a non-ambulatory mechanical restraint to continue longer than one (1) hour.

(g) Non-ambulatory mechanical restraints lasting two (2) hours in duration shall be considered a behavioral health crisis and shall result in an immediate referral to a mental health professional or a mental health facility for assessment and possible treatment.

(h) Under no circumstances shall a non-ambulatory mechanical restraint exceed three (3) hours in duration within a 24 hour period.

(i) Residents in a non-ambulatory mechanical restraint shall be provided:

(1) constant visual supervision by a juvenile supervision officer;

(2) an opportunity for expanded physical motion or movement of not less than five minutes at every 30 minute interval;

(3) an opportunity to drink water every hour;

(4) regularly prescribed medications, unless otherwise ordered by a physician; and

(5) bathroom privileges offered at least every hour.

(j) Requirements enumerated in subsection (i)(1) - (5) of this section shall be fully documented and retained in the facility record or resident file.

(k) The following documentation shall be retained in the facility record or resident file:

(1) an assessment of the resident's circulation, positioning and breathing conducted at least every ten minutes by a specially trained juvenile supervision officer or a health care professional; and

(2) documented checks, performed by a health care professional, or specially trained staff, of the physical condition of the resident and the placement of the mechanical restraint devices within the first 30 minutes of the restraint and every hour thereafter.

(l) The officer responsible for providing the constant visual supervision of a resident in a non-ambulatory mechanical restraint shall have physical possession of the key or other mechanism for releasing the resident from the restraint.

(m) Any juvenile probation officer or juvenile supervision officer authorized to place a resident in a non-ambulatory mechanical restraint, shall be trained in topics that include, but are not limited to:

(1) monitoring the vital signs and critical circulation points of a resident placed in the non-ambulatory mechanical restraint; and

(2) emergency procedures for the removal of a resident from the non-ambulatory mechanical restraint.

§343.816. Chemical Restraints.

In addition to the requirements found in §§343.802, 343.804, and 343.806 of this chapter, the use of chemical restraints shall be governed by the following criteria:

(1) chemical restraints shall only be used in response to episodes of resident riot and only then when other forms of approved physical restraints are deemed to be inappropriate or ineffective;

(2) the use of chemical restraints shall receive incident-specific authorization from the facility administrator or the acting facility administrator. Standing orders authorizing chemical restraints are prohibited;

(3) chemical restraints are restricted to professionally manufactured and commercially available defense sprays and vaporizing agents containing either Oleoresin Capsicum (i.e., OC pepper sprays) or Orthochlorobenzalmalonoitrile (i.e., tear gas);

(4) chemical restraint deployment devices shall be stored in a locked area, and the issuance of these devices to juvenile supervision officers shall not commence until the facility administrator's authorization has been provided;

(5) chemical restraints shall not be used on a resident when he or she is physically restraint (in a personal or mechanical restraint), or otherwise under control;

(6) immediately following the use of a chemical restraint, the exposed resident shall be visually or physically examined by a medical professional and provided treatment if necessary; and

(7) chemical agent compatible neutralizers or decontaminants shall be readily available for use on residents who have been exposed to chemical restraints.

§343.818. Preventative Mechanical Restraints.

For resident, staff, and public safety purposes, a resident may be placed in ankle cuffs, anklets, handcuffs, wristlets or a waist belt absent the imminent threat requirements enumerated in §343.802(c) of this chapter. These types of preventative mechanical restraints are authorized under the following circumstances:

(1) Intra-facility relocation. Mechanical restraints may be used when moving a resident from point to point within a secure facility. The mechanical restraint devices shall be removed upon completion of the resident's relocation.

(2) Vehicular transport. A resident shall not be secured to:

(A) any part of the vehicle; or

(B) another resident.

(3) Off-site activities. Mechanical restraints may be used when a resident is required to leave the secure confines of the facility.

(4) The routine, preventative mechanical restraint applications used in this section are exempt from the documentation requirements contained in §343.806 of this chapter, except when the resident's cooperation is compelled through the use of a personal or chemical restraint; when the resident receives an injury in relation to the restraint event or restraint devices; or when the resident's behavior escalates to the imminent threat criteria listed in §343.802(d) of this chapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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CHAPTER 344. EMPLOYMENT, CERTIFICATION AND TRAINING

The Texas Juvenile Probation Commission proposes new Chapter 344, §§344.100, 344.110, 344.120, 344.200, 344.210, 344.220, 344.230, 344.300, 344.310, 344.320, 344.330, 344.340, 344.400, 344.410, 344.500, 344.510, 344.520, 344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.670, 344.680, 344.700, 344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, and 344.890, relating to employment, certification and training for juvenile officers. These new standards are being proposed in an effort to consolidate and streamline requirements related to employment, certification and training from several other chapters of the Commission's standards. This chapter also introduces several new requirements designed to enhance training and certification requirements for juvenile officers and to simplify the certification process. These standards were originally published in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6753) and are being withdrawn and republished with substantive changes for another thirty day public comment period.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the new rules are in effect, there will be no fiscal implications for state government or small businesses as a result of enforcement or implementation.

As for local government, the implementation of a requirement for participating in the electronic fingerprinting system through the Texas Department of Public Safety requires a fee of $9.95 per person fingerprinted. Local juvenile departments may choose to pay this fee on behalf of their applicants and employees or may choose to require individuals to pay the fee themselves. The amount of fiscal impact for a specific department will be dependent upon the number of staff who must be fingerprinted and upon how the department decides to arrange for payment of the fee. Additionally, it is expected that the reduction in staff time

required to obtain and maintain fingerprint records will offset this new fee.

Changes in the number of required training hours and changes related to the classifications of staff who must received required training may increase training costs. However, several initiatives are being implemented by the Commission to offset this increased cost. These initiatives include: availability of web-based training in live and videotaped formats; increased regional training opportunities; and enhanced website resources, including training curricula and materials for use at the local level.

The new standards also require successful completion of a competency exam for certification. The Texas Juvenile Probation Commission will attempt to implement this requirement at little or no cost to local departments, however it is possible that there will be travel or other costs associated with completion of the exam. Departments may choose to defray these expenses to the individual test taker.

Ms. Capers has also determined that for each year of the first five years the amendment is in effect, the public benefit expected as a result of enforcement or implementation will be to ensure that qualified staff are able to provide services in a safe and effective manner to youth under the supervision of the juvenile court. There will be no impact on small business or individuals as a result of the new rules.

Public comments on the proposed rules may be submitted in writing to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Kristy.Almager@tjpc.state.tx.us* or faxed to (512) 424-6718.

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§344.100, 344.110, 344.120

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by these new rules.

§344.100. Definitions.

The following words and terms, when used in this chapter shall have the following meanings, unless context clearly indicates otherwise.

(1) Applicant--An individual applying for certification as a juvenile probation officer or juvenile supervision officer.

(2) Board--The governing board of the Texas Juvenile Probation Commission.

(3) Certified Officer--A juvenile probation officer or juvenile supervision officer who has met the minimum certification requirements and is currently certified by the Commission.

(4) Chief Administrative Officer--Regardless of title, the person hired by a juvenile board who is responsible for oversight of the day-to-day operations of a single juvenile probation department for a single county or a multi-county judicial district.

(5) Commission--The Texas Juvenile Probation Commission.

(6) Competency Examination--An examination or other assessment instrument required by any statute or Commission rule that governs an individual's certification as a juvenile probation officer or juvenile supervision officer.

(7) Continuing Education--Courses, programs, or organized learning experiences required to maintain certification and to enhance personal or professional goals.

(8) Direct Unsupervised Access--The ability to physically interact with juveniles in a juvenile justice program or facility without the accompanying physical presence of or constant visual monitoring by a certified officer or other authorized employee of the program or facility.

(9) Facility Administrator--An individual designated by the chief administrative officer or governing board of a juvenile justice facility as the on-site program director or superintendent of a secure facility.

(10) Juvenile Justice Facility ("facility")--A facility, including its premises and all affiliated sites, whether contiguous or detached, operated wholly or partly by or under the authority of the governing board, juvenile board or by a private vendor under a contract with the governing board, juvenile board or governmental unit that serves juveniles under juvenile court jurisdiction. The term includes:

(A) A public or private juvenile pre-adjudication secure detention facility, including a short-term detention facility (i.e., holdover) required to be certified in accordance with Texas Family Code §51.12;

(B) A public or private juvenile post-adjudication secure correctional facility required to be certified in accordance with Texas Family Code §51.125, except for a facility operated solely for children committed to the Texas Youth Commission; and

(C) A public or private non-secure juvenile post-adjudication residential treatment facility housing juveniles under juvenile court jurisdiction.

(11) Juvenile Justice Program ("program")--A program or department operated wholly or partly by the governing board, juvenile board or by a private vendor under a contract with the governing board, or juvenile board that serves juveniles under juvenile court jurisdiction or juvenile board jurisdiction. The term includes a juvenile justice alternative education program and a non-residential program that serves juvenile offenders under the jurisdiction of the juvenile court or juvenile board jurisdiction and a juvenile probation department.

(12) Juvenile Probation Department ("department")--All physical offices and premises utilized by a county or district level governmental unit established under the authority of a juvenile board(s) to facilitate the execution of the responsibilities of a juvenile probation department enumerated in Title 3 of the Texas Family Code and Chapter 141 of the Texas Human Resources Code.

(13) Juvenile Probation Officer--An individual whose primary responsibility and essential job function is to provide juvenile probation services and supervision duties authorized under statutory and agency administrative law that can only be performed by an active certified juvenile probation officer in good standing with the Commission.

(14) Juvenile Supervision Officer--An individual whose primary responsibility and essential job function is the supervision of juveniles in a juvenile justice program or juvenile justice facility.

(15) Mandatory Topics--Specified training topics mandated in the Commission's administrative standards designed to provide officers the essential skills and knowledge necessary for

certification and to fulfill the duties and responsibilities of a certified officer.

(16) NCIC--The National Crime Information Center (NCIC) is the Federal Bureau of Investigation's (FBI) database that utilizes fingerprints or other biometric identifiers to track an individual's criminal history in the United States.

(17) One Year of Graduate Study--As described in Texas Human Resources Code §141.061(a)(3)(A), successful completion of at least 18 post-graduate credit hours in criminology, corrections, counseling, law, social work, psychology, sociology, or other field of instruction approved by the Commission at a college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board.

(18) TCIC--Texas Crime Information Center (TCIC) is the Texas Department of Public Safety's database that utilizes fingerprints or other biometric identifiers to track an individual's criminal history in the state of Texas.

(19) Training--An organized, planned and evaluated activity designed to achieve specific learning objectives.

§344.110. Interpretation and Applicability.

(a) Headings. The headings in this chapter are for convenience only and are not intended as a guide to the interpretation of the standards herein.

(b) Conflicting Standards. If a general provision contained in this chapter conflicts with a specific provision contained in another chapter of an administrative standard promulgated by the Commission, the specific language controls.

(c) Applicability. The language contained herein applies to all certifications granted on or after the effective date of this chapter.

(d) Criminal History. Any felony conviction, felony deferred prosecution, felony deferred adjudication, misdemeanor conviction, misdemeanor deferred prosecution, or misdemeanor deferred adjudication occurring before September 1, 2003 will not disqualify a certified officer who held an active certification on September 1, 2003.

§344.120. The Compliance Resource Manual and Implementation of Agency Policy.

The Commission may establish by administrative rule or other reasonable agency policy, the required guidelines, procedures and documentation necessary to ensure compliance and verification of the standards set forth in this chapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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SUBCHAPTER B. QUALIFICATIONS FOR EMPLOYMENT

37 TAC §§344.200, 344.210, 344.220, 344.230

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

The following rules and standards are affected by this subchapter: §349.7 and §341.20 of this title; and Human Resources Code §141.065.

§344.200. General Qualifications for Employment.

(a) Juvenile Probation Officer. To be eligible for employment as a juvenile probation officer, supervisor or chief administrative officer, an applicant shall:

(1) be at least 21 years of age;

(2) be of good moral character and have no disqualifying criminal history as described in this chapter;

(3) have acquired a bachelor's degree conferred by a college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board;

(4) possess the work experience or graduate study required in §344.210 of this chapter; and

(5) never have had any type of certification revoked by lawful authority of the Commission and not be currently under an order of suspension as described in §344.840(d) of this chapter.

(b) Juvenile Supervision Officer. To be eligible for employment as a juvenile supervision officer, an applicant shall:

(1) be at least 21 years of age;

(2) be of good moral character and have no disqualifying criminal history as described in this chapter;

(3) have acquired a high school diploma or equivalent; and

(4) never have had any type of certification revoked by lawful authority of the Commission and not currently be under an order of suspension as described in §344.840(d) of this chapter.

(c) Facility Administrator. To be eligible for employment as a facility administrator, an applicant shall:

(1) meet the minimum requirements to become a juvenile probation officer as described in §344.200(a) of this chapter; and

(2) maintain an active certification as a juvenile supervision officer.

§344.210. Work Experience.

(a) In lieu of the graduate study requirement in §344.500(a)(2) of this chapter, an applicant for the position of juvenile probation officer shall have one year of experience in full-time case work, counseling, community or group work:

(1) in a social service, community, corrections, or juvenile agency that deals with offenders or disadvantaged persons; and

(2) that the Commission has determined provides the kind of experience necessary to meet this requirement.

(b) Internships may be counted toward meeting one year's experience based on actual hours completed when the duties performed were related to the field of juvenile justice.

§344.220. Exemptions from Qualifying Work Experience.

(a) The juvenile board, chief administrative officer or designee shall submit to the Commission a request for exemption of the require-

ment of one year experience or one year graduate study prior to the employment of an applicant who does not meet the one year experience or education requirements for the position of juvenile probation officer.

(b) The exemption request shall be made using the form provided by the Commission and shall document that diligent efforts were made to employ an applicant who meets the work experience requirement.

(c) The chief administrative officer shall provide written notification to the chair of the juvenile board of a request for exemption under this section prior to employment of the applicant.

(d) The Commission shall review and may approve or deny the request.

§344.230. Persons Who May Not Act as Chief Administrative Officers, Juvenile Probation Officers, or Juvenile Supervision Officers.

A peace officer, prosecuting attorney, or other person who is employed by or who reports directly to a law enforcement or prosecution official may not act as a chief administrative officer, juvenile probation officer, or juvenile supervision officer or be made responsible for supervising a juvenile in a juvenile justice facility or program.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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SUBCHAPTER C. CRIMINAL HISTORY SEARCHES

37 TAC §§344.300, 344.310, 344.320, 344.330, 344.340

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

The following rules and standards are affected by this subchapter: §§349.8; 343.302; 343.304; and 343.306 of this title.

§344.300. Criminal History Searches for Positions Requiring Certification.

(a) Fingerprint Search.

(1) Fingerprints shall be submitted through the Texas Department of Public Safety (DPS) Fingerprint Applicant Services of Texas (FAST) system.

(2) The juvenile board, chief administrative officer, facility administrator or designee shall initiate a fingerprint-based criminal history search through the FAST system prior to the first day of employment to confirm that the applicant has no disqualifying criminal history.

(b) Criminal History Clearinghouse. The Commission and the juvenile board or designee shall participate in the electronic clearinghouse and subscription service operated by the DPS. This service, known as the Fingerprint-based Applicant Clearinghouse of Texas (FACT), provides criminal history record information to the Commission, juvenile probation departments and juvenile boards who subscribe to the system. The system notifies the Commission and the chief administrative officer or designee of any disqualifying criminal conduct that may occur subsequent to the date of employment or certification.

(c) Military History. Applicants with prior military experience shall provide a copy of the DD-214 Discharge Form for each tour of duty. In the event a DD-214 reflects character of service as anything other than honorable discharge, the juvenile probation department shall obtain release of information authorization from the applicant and shall request additional information from the appropriate governmental entity to determine whether the reason for discharge was the result of disqualifying criminal conduct.

§344.310. Criminal History Searches for Positions Not Requiring Certification.

(a) Criminal history searches shall be conducted for all personnel providing services in juvenile justice facilities or programs who may have direct unsupervised access to juveniles in the facility or program. Prior to being granted access to juveniles in facilities or programs, criminal history searches shall be completed for the following:

(1) Non-Certified Staff. The chief administrative officer or designee shall conduct criminal history searches in accordance with the requirements set forth in §344.300 of this chapter for staff employed full or part-time by a juvenile justice program or juvenile justice facility in positions that do not require certification.

(2) Volunteers and Interns. The chief administrative officer or designee shall conduct criminal history searches in accordance with the requirements set forth in §344.300 of this chapter for volunteers and interns who provide services in juvenile justice programs and facilities.

(3) Service Providers. Service providers include public or private vendors who provide goods and/or services for the operation, management or administration of juvenile probation services and juvenile justice programs and facilities.

(A) Licensed Service Providers. Programs or facilities licensed by the Texas Department of Family and Protective Services, Texas Department of State Health Services or other state agency are exempt from the requirement to provide documentation of criminal history searches for staff employed in the program or facility. The chief administrative officer or designee shall obtain documentation confirming that the provider's license is in good standing with the licensing entity. The facility or program shall not contract for services with a provider whose license is not in good standing.

(B) Non-Licensed Service Providers. The chief administrative officer or designee shall obtain documentation from the provider's employing entity confirming that fingerprint-based criminal history searches of criminal information databases maintained by the Federal Bureau of Investigation and by the state of Texas have been completed within two years prior to the date of the most recent contract for services.

(b) Department policy shall prohibit direct unsupervised access to juveniles in a juvenile justice program or facility by any person with a disqualifying criminal history as described in §344.400 of this chapter.

(c) The juvenile board may grant an exemption to subsection (b) of this section for personnel described in this subsection whose

criminal history report reflects class B misdemeanor activity. Exemptions shall be reviewed and granted on a case-by-case basis.

(d) The requirements of this section do not apply to the juvenile's attorney, family members or other individuals listed as a juvenile's approved visitors.

(e) The criminal history searches described in this section shall apply to individuals who begin employment or service provision on or after September 1, 2009.

§344.320. Criminal History Searches for Position and Departmental Transfers.

(a) Criminal history searches shall be completed by the employing juvenile justice program or facility in accordance with §344.300 of this chapter when:

(1) an individual who was not previously certified accepts a position requiring certification; or

(2) a certified officer employed in a juvenile probation program or facility accepts simultaneous or subsequent employment in a program or facility operated by or under contract with a different department.

(b) For individuals whose fingerprints are already in the Fingerprint Applicant Services of Texas (FAST) system, the searches may be conducted using the existing prints.

§344.330. Criminal History Searches for Secure Contract Facility Employees.

(a) The juvenile probation department in the county in which a secure pre or post-adjudication facility registered by the Commission and operated by a private vendor under contract with a juvenile board is located shall conduct criminal history searches for facility applicants for certified and uncertified positions as required under §344.300 of this chapter.

(b) The contract facility shall provide the juvenile board or designee with identifying information necessary to conduct the required criminal history searches.

(c) The chief administrative officer or designee shall review the criminal history report and provide a copy of the report to a facility with whom they have a written agreement that:

(1) specifically authorizes access to the information;

(2) limits the use of information to the purposes for which it is given;

(3) ensures the security and confidentiality of the information; and

(4) provides for sanctions if a requirement in paragraphs (1), (2) or (3) of this subsection is violated.

(d) The facility administrator or designee shall contact the referring criminal justice agency to obtain information regarding any arrest for which a disposition has not been reported.

(e) The chief administrative officer or designee shall review the criminal history report to confirm that the applicant has no disqualifying criminal history prior to the applicant's first day of employment.

§344.340. Criminal History Records Retention.

A copy of the initial criminal history report required in this section and any reports reflecting subsequent criminal activity shall be maintained for monitoring purposes for the duration of an individual's employment. These records shall be maintained as long as they are administratively valuable or in accordance with the county's established records retention schedule after the monitoring purpose has been fulfilled.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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SUBCHAPTER D. DISQUALIFYING CRIMINAL HISTORY

37 TAC §344.400, §344.410

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

The following rules and standards are affected by this subchapter: §§349.7; 349.10; 341.23; and 343.320 of this title.

§344.400. Disqualifying Criminal History.

(a) An individual with the following criminal history shall not be eligible for continued employment or certification:

(1) a felony conviction against the laws of this state, another state, or the United States within the past ten (10) years;

(2) a deferred adjudication for a felony against the laws of this state, another state, or the United States within the past ten (10) years;

(3) a current felony deferred adjudication, probation or parole;

(4) a jailable misdemeanor conviction against the laws of this state, another state or the United States within the past five (5) years;

(5) a deferred adjudication for a jailable misdemeanor against the laws of this state, another state, or the United States within the past five (5) years;

(6) a current jailable misdemeanor deferred adjudication, probation or parole; or

(7) the requirement to register as a sex offender under Chapter 62 of the Texas Code of Criminal Procedure.

(b) The offense disposition date shall be used to determine applicable time frames.

(c) In addition to the criteria and time frames set forth in subsection (a) of this section, the applicant shall not be eligible for employment or certification until at least one year has elapsed since the completion of any period of incarceration, community supervision, or parole.

(d) For eligible applicants with a prior criminal history, the department may consider a range of factors to determine the applicant's fitness to perform the duties and discharge the responsibilities of the position.

§344.410. Variance of Disqualifying Criminal History.

A variance under §349.2 of this title may not be requested for any Class A misdemeanor or felony unless the person received a pardon based upon proof of innocence or the reversal of a finding of guilt by a trial or appellate court.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
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SUBCHAPTER E. EDUCATION REQUIREMENTS FOR EMPLOYMENT AND CERTIFICATION

37 TAC §§344.500, 344.510, 344.520

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by these new rules.

§344.500. Education Requirements.

(a) Juvenile Probation Officer. An applicant for employment as a juvenile probation officer must meet the following educational requirements:

(1) have acquired a bachelor's degree conferred by a college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board; and

(2) have one year of graduate study in criminology, corrections, counseling, law, social work, psychology, sociology, or other field of instruction approved by the Commission or qualifying work experience as specified in §344.210 of this chapter.

(b) Juvenile Supervision Officer. An applicant for employment as a juvenile supervision officer must meet one of the following educational requirements:

(1) possess a high school diploma;

(2) a general equivalency diploma from a high school or issuing authority within the United States of America;

(3) a United States military record that indicates the education level received is equivalent to a United States high school diploma or general equivalency diploma;

(4) a foreign high school or home schooling diploma that meets the validation requirements established by the Commission; or

(5) be granted unconditional acceptance into an accredited college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board.

§344.510. Persons Not Subject to Minimum Qualifying Educational Requirements.

(a) Individuals employed as juvenile probation officers prior to September 1, 1981 and who have maintained continuous certification since that date shall not be subject to the minimum educational requirements set forth in Texas Human Resources Code §141.061(a) and in this chapter.

(b) An interruption or lapse of certification under this section shall result in a requirement for the officer to meet all current applicable employment, certification and training requirements.

§344.520. Verification of Education Requirements.

The applicant for employment as a juvenile probation officer or juvenile supervision officer shall provide the department or facility with official documentation that verifies that the applicant meets the educational requirements for certification.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER F. TRAINING AND CONTINUING EDUCATION

37 TAC §§344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.670, 344.680

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

The following rules and standards are affected by this subchapter: §§349.7; 349.15; and 343.16 of this title.

§344.600. Minimum Requirements for Certification.

An applicant for certification as a juvenile probation officer or juvenile supervision officer shall receive a minimum of 80 hours of training including training in mandatory topics described in §344.620 of this chapter prior to certification. Duties that may be performed by individuals hired as juvenile supervision officers or juvenile probation officers prior to their certification are described in applicable chapters under Title 37 of the Texas Administrative Code.

§344.610. Relevance of Training and Standardized Curriculum.

(a) Training must be relevant to the knowledge and skills required in the performance of the officer's job duties to be considered for certification or continuing education credit.

(b) Training in the mandatory topics shall be conducted by training providers who have received specialized training in the curriculum from the Commission or from the employing department.

(c) The standardized curriculum provided by the Commission shall be used in the provision of training on the mandatory topics.

(d) The Commission reserves the right to refuse to approve or grant credit for training hours that do not comply with this standard.

§344.620. Required Training for Certification.

(a) Mandatory Topics. Successful completion of a competency exam based on the following topics is required prior to performing the duties of a certified officer and for certification.

(1) Juvenile Probation Officer.

(A) Role of the probation officer;

(B) Case planning and management;

(C) Recognizing and supervising youth with mental health issues;

(D) Officer safety and mechanical restraints;

(E) Texas Family Code and related laws;

(F) Legal liabilities;

(G) Courtroom proceedings and presentation;

(H) Code of ethics, disciplinary and revocation hearing procedures;

(I) Identifying and reporting abuse, neglect, and exploitation;

(J) Prison Rape Elimination Act; and

(K) Suicide prevention and intervention.

(2) Juvenile Supervision Officer.

(A) Juvenile rights;

(B) Texas Family Code and related laws;

(C) Identifying and reporting abuse, neglect, and exploitation;

(D) Prison Rape Elimination Act;

(E) Suicide prevention and intervention;

(F) Legal liabilities;

(G) Recognizing and supervising youth with mental health issues;

(H) Adolescent physical development and exercise related health risks;

(I) HIV/AIDS and other communicable diseases; and

(J) Code of ethics, disciplinary and revocation procedures.

(b) Additional Requirements for Juvenile Supervision Officer Certification.

(1) Prior to providing resident supervision, all juvenile supervision officers shall receive training and maintain current certification in:

(A) Cardiopulmonary Resuscitation (CPR);

(B) First Aid; and

(C) A Personal Restraint Technique approved by the Commission.

(2) Juvenile supervision officers working in juvenile justice facilities shall receive training in the following additional topics for certification:

(A) Behavior observation and recording;

(B) Behavior management;

(C) Risk management, safety and security;

(D) Medical and health services;

(E) Departmental security, emergency and evacuation procedures;

(F) Facility's suicide prevention plan;

(G) Department procedures for reporting abuse, neglect and exploitation;

(H) Recognizing and responding to medical and mental health needs of residents;

(I) Supervising residents in seclusion;

(J) Facility's fire drill procedures;

(K) Grievance procedures;

(L) Confidentiality of information;

(M) Cultural diversity;

(N) Use of restraints; and

(O) Transportation.

§344.630. On-the-Job Training Requirements.

(a) A juvenile justice program or juvenile justice facility may implement a structured on-the-job training program for use in meeting certification and continuing education requirements.

(b) The training program shall utilize the format developed by the Commission or an equivalent format developed by the department to document the provision of on-the-job training.

(c) The chief administrative officer, facility administrator or designee shall select staff, based on experience, qualifications and/or education, to provide on-the-job training.

(d) A maximum of 40 hours of on-the-job training provided in accordance with this section may be used to meet the certification or continuing education requirement in a given reporting period.

§344.640. Continuing Education Requirements for Maintaining Certification.

(a) A juvenile probation officer or juvenile supervision officer shall complete a minimum of 80 hours training every 24 months in topics related to the officer's job duties and responsibilities in order to maintain an active certification:

(1) For juvenile supervision officers, this training shall include training in the facilities suicide prevention plan and training required to maintain certification in CPR, First Aid and personal restraint technique approved by the Commission.

(2) For chief administrative officers and facility administrators, this training shall include a minimum of 20 hours of management training.

(b) A maximum of 20 hours of training credit that exceeds the minimum requirement in a specific reporting period may be applied to the next reporting period.

(c) Documentation of the required continuing education shall be submitted to the Commission through the Commission's automated certification information system within 24 months of the initial certification date and every 24 months thereafter based on the officer's birth month.

§344.650. Non-Compliance with Training and Continuing Education Requirements.

(a) Failure to comply with §344.640 of this chapter shall result in the following:

(1) the officer's certification shall be placed on inactive status;

(2) the officer shall be restricted from performing the duties of a certified officer; and

(3) the officer shall be ineligible for salary adjustment funding from the Commission.

(b) The officer's certification will be returned to active status upon receipt of documentation that the required continuing education has been completed.

§344.660. Approval and Review of Training Topics.

(a) Approval of Training Topics. All certification and continuing education training shall be approved by the Commission. Training that is not applicable to the duties of a certified officer shall not be applied to the individual's certification or continuing education requirements.

(b) Review of Topics. A juvenile probation department may request a review of the Commission's decision to not approve a topic for certification credit. In support of the request, the juvenile probation department shall describe how the topic relates to the job duties and responsibilities of the officer. The Commission may request additional documentation to evaluate the appropriateness of the topic.

§344.670. Training Methods and Limitations.

(a) Limits on Topics.

(1) Repetitive Training. Credit shall not be allowed for training that is duplicative in nature unless the training is required to maintain certification, such as for CPR or First Aid, or is required to maintain an understanding of the officer's job duties and responsibilities. Topics listed in §344.620 of this chapter are exempt from this limitation.

(2) Review of Policy and Procedure. Credit for policy and procedure review shall be allowed when documentation reflects that the review was part of a structured training event.

(3) Human Resources Training. Training on employment related benefits and plans shall not be accepted for certification purposes unless the officer is a supervisor and the training relates to supervisory duties or the training is being provided as part of a formal leadership development program.

(b) Limitations on Training Methods. The limits in this subchapter apply to continuing education credits earned in a given 24 month period.

(1) Correspondence Courses. A maximum of 40 hours of continuing education credit may be earned for the successful completion of correspondence courses provided by recognized criminal justice organizations or accredited colleges or universities. Correspondence courses may not be used to meet the requirement for training in the mandatory training topics.

(2) Video-Conferencing and Web-Based Training. Credit for a combined total of 40 hours of video conferencing and web-based training methods may be applied toward certification and continuing education requirements.

(3) Video Training. A maximum of 20 hours of video training that is part of a structured training program may be applied to certification or continuing education requirements.

(4) Training Hours for Curriculum Development. A maximum of 10 hours of credit in a given continuing education period may be allowed for the development of training curriculum.

(5) Training Providers. Training providers may claim actual training time up to a maximum of 10 hours for the provision of training. The credit under this section is allowed only for the provision of training in topics listed in §344.620 of this chapter.

(6) Meetings/Staff Meetings. Meetings shall not be considered a training activity unless supporting documentation indicates that all or part of the meeting was designated solely for the purpose of training.

(7) College Courses. Up to 40 hours of continuing education credit may be applied for successful completion of a three-hour college course in a topic relevant to the officer's job duties and that is provided by a college or university accredited by an organization recognized by the Texas Higher Education Coordinating Board and approved by the Commission. Classes for which less than three hours of college credit is earned may be considered for continuing education credit. If approved, continuing education hours will be based on the number of classroom hours.

§344.680. Documentation.

Documentation of all training received shall be maintained in the department or facility's files for monitoring purposes. Documentation may include sign-in sheets, agendas, certificates of completion, correspondence from the instructor, registration receipts, and/or exam results. The chief administrative officer or designee shall, upon request, submit training records to a juvenile probation department in which an officer has obtained subsequent employment.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900127
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER G. COMPETENCY EXAMINATION

37 TAC §344.700

This standard is proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new rule.

§344.700. Competency Examination Requirement.

(a) A juvenile probation officer or juvenile supervision officer shall pass the competency exam prescribed by the Commission in order to be eligible for certification.

(b) A juvenile probation officer or juvenile supervision officer shall complete the mandatory training required in §344.620(a)(1) or (2) of this chapter prior to attempting the competency exam.

(c) The Commission shall establish a plan for the administration of the examination, including any required fees.

(d) The Commission shall determine the satisfactory level of performance.

(e) Scores shall be sent electronically or by other means established by the Commission to the examinee and the chief administrative officer or designee upon completion of the exam.

(f) The Commission shall maintain a record of competency examination results.

(g) The requirements of this subchapter apply to applicants for positions requiring certification who begin employment as juvenile probation officers on or after September 1, 2011 or who begin employment as juvenile detention officers on or after September 1, 2012.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
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Texas Juvenile Probation Commission
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SUBCHAPTER H. CERTIFICATION

37 TAC §§344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, 344.890

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

The following rule is affected by this subchapter: §349.8 of this title.

§344.800. Positions Requiring Certification.

Certain positions require certification by the Commission in order to perform the job functions of the position. Positions requiring certification are specified in applicable chapters under Title 37 of the Texas Administrative Code.

§344.810. Eligibility for Certification.

To be eligible for certification, an individual must:

(1) be twenty-one years of age or older;

(2) have achieved the level of education required for the certification, or been granted an exemption from this requirement;

(3) be of good moral character and have no disqualifying criminal history as described in this chapter;

(4) not be currently under an order of suspension issued under the lawful authority of the Commission;

(5) never have had any type of certification revoked by lawful authority of the Commission;

(6) have satisfactorily completed all pre-service training required by the Commission;

(7) have passed the competency examination as required by the Commission; and

(8) be employed by a governmental unit or a public or private vendor under contract with a governmental unit.

§344.820. Length of Certification.

The Commission may issue a non-expiring certification to individuals who meet the eligibility requirements under this chapter.

§344.830. Certification Renewal Period.

The employing juvenile justice program or facility shall submit, within 24 months of the initial certification date and every 24 months thereafter based on the officer's birth month, documentation that:

(1) the officer has completed the continuing education requirements in §344.640 of this chapter, and

(2) the criminal history search requirements in §344.300 of this chapter have been met.

§344.840. Certification Status.

(a) Active. An officer shall be required to maintain an active certification in order to perform the duties of a juvenile probation officer or juvenile supervision officer. The individual and the employing department shall ensure that all requirements under this chapter are met in order to maintain the certification in active status. An active certification status requires that the officer shall have:

(1) no disqualifying criminal history;

(2) no current suspension or revocation of certification under the lawful authority of the Commission; and

(3) met the continuing education requirements set forth in §344.640 of this chapter.

(b) Inactive. An officer's certification shall be placed on inactive status in the event that the certification application is found to have a defect or flaw, the officer fails to meet reporting requirements or is no longer employed by a juvenile probation department. An individual whose certification is inactive is not eligible to perform the duties of a certified officer or to receive salary adjustment funds from the Commission. The juvenile probation department shall submit documentation through the Commission's automated certification system that an officer has completed all reporting requirements in accordance with §344.830 of this chapter in order to reactivate the officer's certification.

(c) Provisional. The Commission may issue a provisional certification for a period not to exceed 180 calendar days to an individual whose educational credentials require evaluation or verification. During the provisional certification period, the officer may perform the duties of a certified officer. In the event that the education validation is denied or is not validated within the 180 calendar day period, the individual is no longer eligible to perform the duties of a juvenile probation or supervision officer.

(d) Suspended. An officer who is currently under an order of suspension is not eligible for certification by the Commission and shall not perform the duties of a certified officer. A suspension order shall be in effect until the date determined in the disciplinary hearing held by the Commission. In the event of suspension for failure to pay child support under §232.003 of the Texas Family Code, the suspension shall remain

in effect until the Commission receives an order staying or vacating the suspension.

(e) Revoked. An officer who has had a certification revoked by lawful authority of the Commission is no longer eligible for employment or certification as a juvenile probation officer or juvenile supervision officer.

§344.850. Employment by a Governmental Unit.

A juvenile probation officer or juvenile supervision officer with a certification issued by the Commission under this chapter shall be employed by a governmental unit or a private provider under a contract with a governmental unit to maintain active status. The Commission shall place the officer's certification on inactive status upon receiving notification of the individual's resignation or termination from employment from the governmental unit.

§344.860. Certification Process.

(a) Submission of Applications. All certification applications shall be submitted through the Commission's automated certification information system.

(1) Chief Administrative Officers. The juvenile board or designee shall review the certification documentation and approve in writing the submission of the certification application for a chief administrative officer prior to submission of the application to the Commission.

(2) Facility Administrators. The juvenile board or the chief administrative officer shall review the certification documentation and approve in writing the submission of the certification application for a facility administrator prior to submission of the application to the Commission.

(3) Juvenile Probation Officer. The chief administrative officer or designee shall submit the certification application for a juvenile probation officer.

(4) Juvenile Supervision Officer. The chief administrative officer, facility administrator, or designee shall submit the certification application for a juvenile supervision officer.

(b) Timeline for Submission. The certification application shall be submitted to the Commission no more than 180 calendar days from the date of initial employment.

(1) An individual whose application for certification has not been submitted within this time frame:

(A) shall not perform the duties of a certified officer; and

(B) shall not count toward the program's staff to child ratios.

(2) An extension of up to 90 days may be allowed for part time staff who have not completed the required training.

(c) Valid Criminal History Searches. Criminal history searches shall have been completed within 180 days prior to submission of the certification application. Dates of return shall be included in the certification application.

(d) Approval of Applications. The Commission shall review information contained in an application to determine certification eligibility. The Commission shall reserve the right to request additional information or documentation. The juvenile probation department will be notified of certification decisions through the Commission's automated certification information system. Any officer whose application is denied shall not perform the duties of a certified officer.

(e) Juvenile Officer Training Tracking System (JOTTS). The juvenile probation department shall utilize the Commission's training and tracking system or an equivalent automated system to document training and continuing education received by certified officers. Training information shall be included in the certification application and submitted through the Commission's automated certification system.

§344.870. Requests for Extension.

(a) The Commission may grant an extension in the event of an unexpected extended absence from employment to allow a certified officer additional time to obtain training necessary to maintain active certification status.

(b) Approved extensions will be granted in increments up to 90 calendar days from the date the certification renewal information was due. Additional time may be requested in special circumstances such as leave under the Family Medical Leave Act (FMLA) or worker's compensation leave.

(c) An officer whose absence is due to leave for military duty will be granted an amount of time equal to the amount of military leave up to a maximum of 24 months.

(d) An officer who does not satisfy all requirements necessary to maintain active status within the extension period shall not perform the duties of a certified officer or receive salary adjustment funds from the Commission.

§344.880. Transfer or Reactivation of Certification.

(a) The employing juvenile justice program or facility shall request through the commission's automated certification system that an officer's certification be transferred or reactivated when an officer is hired who is currently certified and employed in another juvenile probation department or is returning from inactive status.

(b) Active Certification.

(1) The juvenile board, chief administrative officer or designee shall request a transfer of certification when an officer with an active certification obtains employment in a position for which certification is required.

(2) The request for transfer shall include verification that all criminal history searches have been completed in accordance with §344.300 of this chapter.

(c) Inactive Certification.

(1) The juvenile board, chief administrative officer or designee shall request a transfer of certification when an officer whose certification is inactive obtains employment in a position for which certification is required.

(2) The request for transfer shall include verification that all criminal history searches have been conducted in accordance with §344.300 of this chapter.

(3) Completion of 80 hours of continuing education within the 24 months prior to employment shall be confirmed and documentation included in the officer's personnel file prior to submission of the transfer request.

(d) Training Records. The juvenile board, chief administrative officer, facility administrator, or designee shall forward a certified officer's training records to the employing facility or program, upon request, when an officer's certification is transferred.

§344.890. Termination of Employment.

The juvenile board, chief administrative officer, or designee shall notify the Commission of the resignation or termination of individuals

employed in positions requiring certification within 10 working days of the date of their separation from employment. Upon receipt of notice, the Commission shall place the certified officer's certification on inactive status.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

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Lisa A. Capers
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Texas Juvenile Probation Commission
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CHAPTER 350. INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§350.100, 350.110, 350.120, 350.200, 350.210, 350.220, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, 350.900 - 350.904

The Texas Juvenile Probation Commission proposes new Chapter 350, §§350.100, 350.110, 350.120, 350.200, 350.210, 350.220, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, and 350.900 - 350.904, relating to investigating abuse, neglect, exploitation, death and serious incidents by the Texas Juvenile Probation Commission. These new standards are being proposed in an effort to ensure that the agency's investigators have the ability to conduct comprehensive investigations in a more timely and efficient manner. These standards were originally published in the August 22, 2008, issue of the *Texas Register* and are being withdrawn and republished with substantive changes for another thirty day public comment period.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the new rules are in effect, there will be no fiscal implications for state government, local government or small businesses as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the new rules are in effect, the public benefit expected as a result of enforcement or implementation will be the ability to conduct more efficient and comprehensive investigations which will provide a greater level of safety for the juveniles and communities we serve. There will be no impact on small business or individuals as a result of the amendments.

Public comments on the proposed rules may be submitted in writing to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Kristy.Almager@tjpc.state.tx.us* or faxed to (512) 424-6718.

These rules are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other statutes, articles, or codes will be affected.

§350.100. Definitions.

(a) The terms used in this Chapter apply to the investigations of allegations of abuse, neglect, exploitation, death and serious incidents conducted by the Commission and to the Commission's procedures relating to serious incidents.

(b) Terms used in this Chapter shall have the following meanings unless otherwise expressly defined within the Chapter.

(1) Abuse, Neglect and Exploitation--The definitions of "abuse", "neglect" and "exploitation" shall have the meanings defined in Texas Family Code §261.001 and §261.401. This term also includes the definitions of serious physical abuse and sexual abuse herein.

(2) Administrator--The chief administrative officer of a juvenile probation department, a public or private juvenile justice program or an administrator of a public or private juvenile justice facility.

(3) Administrative Designee--The role assigned to the administrator, when at the conclusion of an investigation, a preponderance of evidence determines that the proximate cause of the allegation was based on policies and procedures under the direct control of the administrator.

(4) Alleged Perpetrator--A person alleged as being responsible for the abuse, neglect or exploitation of a juvenile through the person's actions or failure to act.

(5) Alleged Victim--A juvenile under the jurisdiction of the juvenile court or participating in a program operated under the authority of the governing board or juvenile board who is alleged to be a victim of abuse, neglect or exploitation.

(6) Attempted Suicide--Any voluntary and intentional action that could reasonably result in taking one's own life.

(7) Call Line--The toll-free line made available by the Commission to juveniles, professionals and private citizens for the purpose of reporting allegations of abuse, neglect, exploitation, death and serious incidents within the juvenile justice system.

(8) Commission--The Texas Juvenile Probation Commission.

(9) Death--The permanent cessation of vital bodily functions.

(10) Designated Perpetrator--The individual responsible for the abuse, neglect or exploitation of a juvenile who has not exhausted the right to administrative review or whose right to administrative review has not expired.

(11) Designated Victim--The juvenile who was abused, neglected or exploited.

(12) Escape--"Escape" means:

(A) The voluntary, unauthorized departure, or attempt to depart, by an individual who is in custody; or

(B) Failure to return to custody following an authorized temporary leave for a specific purpose or limited period.

(13) Incident Report Form--The required form used to report to the Commission allegations of abuse, neglect, exploitation, death and serious incidents.

(14) Internal Investigation Report--The written report submitted to the Commission that summarizes the steps taken and the ev-

idence collected during an internal investigation of an allegation of abuse, neglect, exploitation or death.

(15) Juvenile--A person who is under the jurisdiction of the juvenile court, confined in a juvenile justice facility, or participating in a juvenile justice program.

(16) Juvenile Justice Facility ("facility")--A facility, including its premises and all affiliated sites, whether contiguous or detached, operated wholly or partly by or under the authority of the governing board, juvenile board or by a private vendor under a contract with the governing board, juvenile board or governmental unit that serves juveniles under juvenile court jurisdiction. The term includes, but is not limited to:

(A) A public or private juvenile pre-adjudication secure detention facility, including a short-term detention facility (i.e., holdover) required to be certified in accordance with Texas Family Code §51.12;

(B) A public or private juvenile post-adjudication secure correctional facility required to be certified in accordance with Texas Family Code §51.125, except for a facility operated solely for children committed to the Texas Youth Commission; and

(C) A public or private non-secure juvenile post-adjudication residential treatment facility housing juveniles under juvenile court jurisdiction.

(17) Juvenile Justice Program ("program")--A program or department operated wholly or partly by the governing board, juvenile board or by a private vendor under a contract with the governing board, or juvenile board that serves juveniles under juvenile court jurisdiction or juvenile board jurisdiction. The term includes a juvenile justice alternative education program and a non-residential program that serves juvenile offenders under the jurisdiction of the juvenile court or juvenile board jurisdiction and a juvenile probation department.

(18) Juvenile Probation Department ("department")--All physical offices and premises utilized by a county or district level governmental unit established under the authority of a juvenile board(s) to facilitate the execution of the responsibilities of a juvenile probation department enumerated in Title 3 of Texas Family Code and Chapter 141 of Texas Human Resources Code.

(19) Peace Officer--A person elected, employed, or appointed as a peace officer under Code of Criminal Procedure, Article 2.12.

(20) Report--Formal notification to the Commission of an allegation of abuse, neglect, exploitation or death or of a serious incident.

(21) Reportable Injury--Any injury sustained accidentally, intentionally, recklessly or otherwise that:

(A) Requires medical treatment; or

(B) Results from a personal, mechanical or chemical restraint and is a substantial injury.

(22) Serious Incident--Any incident that is an attempted escape, attempted suicide, escape, reportable injury, youth-on-youth physical assault or youth sexual conduct.

(23) Serious Physical Abuse--Bodily harm or condition that resulted directly or indirectly from the conduct that formed the basis of an allegation of abuse, neglect or exploitation, if the bodily harm or condition requires medical treatment.

(24) Sexual Abuse--Conduct committed by any person against a juvenile that includes sexual abuse by contact or sexual abuse by non-contact. A juvenile, regardless of age, may not affirmatively or impliedly consent to the acts as defined herein under any circumstances.

(25) Sexual Abuse by Contact--Any physical contact with a juvenile that includes: intentional touching of the genitalia, anus, groin, breast, inner thigh or buttocks with the intent to abuse, intimidate, hurt, humiliate or harass, arouse or gratify sexual desire; deviate sexual intercourse; sexual contact; sexual intercourse; or sexual performance as those terms are defined below.

(A) "Deviate sexual intercourse" means:

(i) any contact between any part of the genitals of one person and the mouth or anus of another person; or

(ii) the penetration of the genitals or the anus of another person with a hand, finger or other object.

(B) "Sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(i) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a person; or

(ii) any touching of any part of the body of a person, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(C) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(D) "Sexual performance" means acts of a sexual or suggestive nature performed in front of one or more persons including simulated or actual sexual intercourse, deviate sexual intercourse, bestiality, masturbation, sado-masochistic abuse or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.

(26) Sexual Abuse by Non-Contact--Any sexual behavior, conduct, harassment or actions other than those defined by sexual abuse by contact, which are exhibited, performed or simulated:

(A) in the presence of a juvenile or with reckless disregard for the presence of a juvenile;

(B) with the intent to arouse or gratify the sexual desire of any person;

(C) with the intent to intimidate, hurt, humiliate or harass any person;

(D) including repeated verbal statement or comments of a sexual nature; and

(E) including demeaning references to gender, derogatory comments about body or clothing or profane or obscene language or gestures.

(F) These behaviors, conduct and actions include indecent exposure, voyeurism, distribution or exhibition of pornographic or sexually explicit material or sexual performance as defined in §350.100(b)(26)(D) of this section.

(27) Substantial Injury--An injury that is significant in size, amount or severity.

(28) Sustained Perpetrator--A designated perpetrator who has already been offered the right to an administrative review and the designated perpetrator's rights to the administrative review have expired or the disposition was upheld.

(29) TCLEOSE--Texas Commission on Law Enforcement Officer Standards and Education.

(30) Youth-on-Youth Physical Assault--A physical altercation between two or more juveniles that results in any of the involved parties sustaining an injury that requires medical treatment.

(31) Youth Sexual Conduct--Two or more juveniles, regardless of age, who engage in deviate sexual intercourse, sexual contact, sexual intercourse, sexual performance as those terms are defined in paragraph (26) of this subsection or sexual behavior, conduct or actions which are exhibited, performed or simulated as those terms are defined in paragraph (27) of this subsection. A juvenile may not consent to the acts as defined herein under any circumstances. Consent may not be implied regardless of the age of the juvenile.

§350.110. Interpretation.

(a) Headings. The headings in this chapter are for convenience only and are not intended as a guide to the interpretation of the standards herein.

(b) Including. The word, "including" when following a general statement or term, is not to be construed as limiting the general statement or term to any specific item or manner set forth or to similar items or matters, but rather as permitting the general statement or term to refer also to all other items or matters that could reasonably fall within its broadest possible scope.

§350.120. Applicability.

Unless otherwise noted, these standards apply to the investigations conducted by the Commission of all allegations of abuse, neglect and exploitation, death and serious incidents involving a juvenile and an employee, intern, volunteer, contractor or service provider.

(1) Texas Family Code §261.405(b) gives the Commission the authority to conduct abuse, neglect and exploitation investigations in any juvenile justice department, program or facility. The investigations conducted by the Commission are governed by Texas Family Code Chapter 261.

(2) Investigations of abuse, neglect, exploitation and death are conducted by investigators specifically trained to conduct investigations in juvenile justice departments, programs and facilities. The primary objective of each investigation is to ensure the health, safety and well being of the alleged victim and other juveniles under the jurisdiction of the juvenile court. Investigations also serve to assess additional risk potential and compliance with applicable administrative standards.

§350.200. Abuse, Neglect, Exploitation and Death.

Upon receipt of an allegation of abuse, neglect, exploitation or death, Commission investigators shall assess the allegation to determine the assignment of the initial priority level, which thereby determines the timeframe for initiating the investigation.

§350.210. Assessment.

An assessment shall be completed on all reports of alleged abuse, neglect, exploitation or death received by the Commission.

(1) Allegations within the Commission's investigative jurisdiction shall, regardless of the source, or severity or perceived lack thereof, be assigned for investigation.

(2) Allegations not within the Commission's investigative jurisdiction shall be referred to the appropriate division within the Commission or other government agency having jurisdiction.

§350.220. Prioritization, Activation and Initiation.

(a) Prioritization. All reports of alleged abuse, neglect, exploitation or death shall be assigned a priority level.

(b) Activation. Investigations are activated when the Commission makes the initial notification to law enforcement.

(c) Initiation. Investigations are initiated when the assigned investigator contacts or attempts to contact, via phone, fax, e-mail or in person a representative of the department, program, facility, governing board, juvenile board; law enforcement agency; the reporter; or any person with knowledge of the alleged incident.

§350.300. Investigations.

Investigations shall be conducted to ensure the health, safety and well being of juveniles, employees, interns, volunteers, contractors and service providers. Investigations are also conducted to determine if the alleged incident occurred and to determine if the elements of the alleged incident correspond to the statutory definitions in Texas Family Code Chapter 261.

§350.400. Notification and Referral.

(a) Notification of Disposition. At the conclusion of a case assigned for investigation, notification of the disposition shall be forwarded to the appropriate parties.

(b) Notice to Prosecutor. Notifications to the district or county attorney's office prosecuting criminal matters in the jurisdiction in which the Commission conducted the investigation, shall be forwarded in accordance with applicable Commission policies and procedures.

(c) Non-Compliance Citation Report. A Non-Compliance Citation Report (NCCR) shall be issued when, during the course of an investigation, a violation of Title 37, Part 11, Texas Administrative Code occurred.

(d) Notice of Technical Assistance. A "Notice of Technical Assistance" (NTA) shall be issued regarding any information received during the course of a Commission investigation in which substantial evidence demonstrates that circumstances exists that pose or may pose a potential risk to juveniles and/or staff, but in which it does not appear as though a violation of the Texas Administrative Code occurred.

(e) Referrals. Information received by the Commission that is determined not to be an allegation of abuse, neglect, exploitation or death or that does not fall within the Commission's investigative jurisdiction shall be routed to the appropriate division within the Commission to the agency, department, program or facility in which the incident is alleged to have occurred or to the government agency with investigative jurisdiction.

§350.500. Requests for Disciplinary Action.

Requests for disciplinary action shall be submitted in accordance with applicable agency administrative standards, policies and procedures.

§350.600. Retention, Release and Redaction of Commission Records.

(a) Record Development. In accordance with Texas Family Code §261.402, the Commission shall develop and maintain a record of each reported alleged incident of abuse, neglect, exploitation or death.

(b) Database. The Commission shall maintain an electronic database containing information regarding all reports of alleged incidents of abuse, neglect, exploitation, death and serious incidents.

(c) Preservation of Recordings and Transcripts. Recorded interviews and transcripts of recorded interviews maintained by the Commission shall be preserved in accordance with the Commission's record retention schedule and other applicable laws.

(d) Record Retention. The investigation records maintained by the Commission are confidential and shall be retained in accordance with the retention schedule adopted by the Commission or other applicable laws.

§350.610. Release of Confidential Information.

Confidential information shall be released in accordance with the Commission's policies and procedures and other applicable statutory provisions governing the disclosure of confidential information.

§350.620. Redaction of Records.
In certain cases, an alleged perpetrator's identifying information may be redacted from the Commission's records.

(1) Automatic Redaction. The Commission shall, in cases in which the disposition is baseless, automatically and permanently redact the alleged perpetrator's identifying information from the Commission's case record.

(2) Request for Redaction. The alleged perpetrator may request that his or her identifying information be redacted from the Commission's records if:

(A) The Commission's final disposition of the case in which the alleged perpetrator was involved is "Ruled Out";

(B) The alleged perpetrator submits the request for redaction in writing to the Commission's Legal Division;

(C) The alleged perpetrator submits the request for redaction within 30 calendar days of the last day of the corresponding limitation period described in this paragraph;

(D) The alleged perpetrator has been continuously employed within the Texas juvenile justice system for the time period as specified in this paragraph; and

(E) The alleged perpetrator has not been named as the subject of investigation in a subsequent case of abuse, neglect or exploitation.

(3) Limitation Periods. A request for redaction may only be made if all requirements of paragraph (1) of this section are met and if:

(A) Two years has expired from the date of the Commission's final disposition of "Ruled Out", and if, notwithstanding a violation of the Texas Administrative Code, the investigation of the alleged abuse, neglect or exploitation did not produce evidence of a violation of laws of this state or of the United States;

(B) Three years has expired from the date of the Commission's final disposition of "Ruled Out", if the allegation does not meet the elements of paragraph (1) or (3) of this section; or

(C) Five years has expired from the date of the Commission's final disposition of "Ruled Out", if the allegation involved serious physical abuse as defined by §358.100(b)(24) of this title or sexual conduct as defined by §358.100(b)(25), (26) or (27) of this title.

§350.700. Call Line.
To facilitate the reporting of allegations of abuse, neglect, exploitation, death and serious incidents, the Commission shall make available a toll-free call line to juveniles, parents, juvenile justice professionals and other concerned citizens.

§350.800. Serious Incidents.
An assessment shall be completed on all reported serious incidents received by the Commission to determine jurisdiction, classification and if follow-up action is needed. Based on the information received by the Commission, any report of a serious incident may be reclassified and assigned for investigation.

§350.900. Training and Quality Assurance.
Commission investigators shall receive current and relevant training in the discipline of investigating allegation of abuse, neglect, exploitation and death. Quality assurance measures shall be implemented to help ensure that Commission investigations are conducted in accordance with the rules contained herein and in accordance with the Commission's Abuse and Neglect Division's policies and procedures.

§350.901. Pre-Service Training.
Investigators shall receive pre-service training hours in the laws, statutes, administrative rules and agency policies and procedures governing and relevant to conducting administrative investigations of abuse, neglect, exploitation and death of juveniles within the juvenile justice system. Pre-service training, including structured and applied on-the-job training, shall be relevant to the knowledge and skills required for the performance of the investigator's job duties. All training shall be received from credible sources, knowledgeable in the specific training course.

§350.902. Competency Testing.
Investigators shall demonstrate through written examination, a minimum proficiency in select topics received during pre-service training.

§350.903. Continuing Education.
Continuing education shall consist of topics relevant to conducting investigations of abuse, neglect, exploitation and death of juveniles within the juvenile justice system and topics relevant to the practices of juvenile justice professionals.

(1) Investigators shall successfully complete a minimum number of hours of continuing education training every training unit.

(2) In addition to the requirements of paragraph (1) of this section, investigators licensed as peace officer shall adhere to the training requirements in accordance with the administrative rules as established by TCLEOSE in Title 37, Part 7 of the Texas Administrative Code.

§350.904. Quality Assurance.
During each fiscal year internal quality assurance reviews of active and completed investigations shall be conducted.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900131
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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CHAPTER 358. IDENTIFYING, REPORTING AND INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460, 358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, 358.920

The Texas Juvenile Probation Commission proposes new Chapter 358, §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460,

358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, and 358.920, relating to indentifying, reporting and investigating abuse, neglect, exploitation, death and serious incidents in departments, programs and facilities. These new rules are being proposed to provide the departments, programs and facilities more comprehensive and well-formulated guidelines for identifying and reporting allegations of abuse, neglect and exploitation.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the new rules are in effect, there will be no fiscal implications for small businesses as a result of enforcement or implementation. The fiscal implications for state government, in particular, the Texas Juvenile Probation Commission will be minimal. The Texas Juvenile Probation Commission will provide the signage the facilities will be required to post regarding a juvenile's right and ability to report allegations of abuse, neglect and exploitation under §358.480. The fiscal impact to the local (county) government, if any, will be minimal. Local governments may opt to install a special phone line to accommodate the call-line as described under §358.440; however, taking such action is not a requirement of the standard and would be a voluntary expenditure.

Ms. Capers has also determined that for each year of the first five years these new rules are in effect, the public benefit expected as a result of enforcement or implementation will be to provide additional protections for the juveniles served throughout the juvenile justice system. There will be no impact on small business or individuals as a result of these rules.

Public comments on the proposed rules may be submitted in writing to Kristy M. Almager at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Kristy.Almager@tjpc.state.tx.us* or faxed to (512) 424-6718.

These rules are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other statutes, codes or articles are affected by this proposal.

§358.100. Definitions.

Terms used in this chapter shall have the following meanings unless otherwise expressly defined within the chapter.

(1) Abuse, Neglect, or Exploitation--The definitions of "abuse," "neglect" and "exploitation" shall have the meaning ascribed under Texas Family Code §261.001 and §261.401. This term also includes the definitions of serious physical abuse and sexual abuse in paragraphs (23) and (24) of this section.

(2) Administrator--The chief administrative officer of a juvenile probation department, a public or private juvenile justice program or an administrator of a public or private juvenile justice facility.

(3) Alleged Victim--A juvenile under the jurisdiction of the juvenile court or participating in a program operated under the authority of the governing board or juvenile board who is alleged to be a victim of abuse, neglect or exploitation.

(4) Attempted Suicide--Any voluntary and intentional action that could reasonably result in taking one's own life.

(5) Call Line--The toll-free line made available by the Commission to juveniles, professionals and private citizens for the purpose of reporting allegations of abuse, neglect, exploitation and serious incidents within the juvenile justice system.

(6) Commission--The Texas Juvenile Probation Commission.

(7) Death--The permanent cessation of all vital bodily functions.

(8) Escape--

(A) The voluntary, unauthorized departure, or attempt to depart, by an individual who is in custody; or

(B) Failure to return to custody following an authorized temporary leave for a specific purpose or limited period.

(9) Founded--The finding assigned to an internal investigation when the evidence indicates that the conduct, which formed the basis of an allegation of abuse, neglect or exploitation, occurred.

(10) Incident Report Form--The required form used to report to the Commission allegations of abuse, neglect, exploitation, death and serious incidents.

(11) Inconclusive--The finding assigned to an internal investigation when the evidence does not clearly indicate whether or not the conduct, which formed the basis of an allegation of abuse, neglect or exploitation, occurred.

(12) Internal Investigation--A formalized and systematic inquiry conducted by the administrator or designee of a juvenile probation department, juvenile justice program or juvenile justice facility in response to an allegation of abuse, neglect, exploitation or death.

(13) Internal Investigation Report--The written report submitted to the Commission that summarizes the steps taken and the evidence collected during an internal investigation of an alleged incident of abuse, neglect, exploitation or death.

(14) Juvenile--A person who is under the jurisdiction of the juvenile court, confined in a juvenile justice facility, or participating in a juvenile justice program.

(15) Juvenile Justice Facility ("facility")--A facility, including its premises and all affiliated sites, whether contiguous or detached, operated wholly or partly by or under the authority of the governing board, juvenile board or by a private vendor under a contract with the governing board, juvenile board or governmental unit that serves juveniles under juvenile court jurisdiction. The term includes, but is not limited to:

(A) A public or private juvenile pre-adjudication secure detention facility, including a short-term detention facility (i.e., holdover) required to be certified in accordance with Texas Family Code §51.12;

(B) A public or private juvenile post-adjudication secure correctional facility required to be certified in accordance with Texas Family Code §51.125, except for a facility operated solely for children committed to the Texas Youth Commission; and

(C) A public or private non-secure juvenile post-adjudication residential treatment facility housing juveniles under juvenile court jurisdiction.

(16) Juvenile Justice Program ("program")--A program or department operated wholly or partly by the governing board, juvenile board or by a private vendor under a contract with the governing board, or juvenile board that serves juveniles under juvenile court jurisdiction or juvenile board jurisdiction. The term includes a juvenile justice alternative education program and a non-residential program that serves

juvenile offenders under the jurisdiction of the juvenile court or juvenile board jurisdiction and a juvenile probation department.

(17) Juvenile Probation Department ("department")--All physical offices and premises utilized by a county or district level governmental unit established under the authority of a juvenile board(s) to facilitate the execution of the responsibilities of a juvenile probation department enumerated in Title 3 of the Texas Family Code and Chapter 141 of the Texas Human Resources Code.

(18) Medical Treatment--Medical care, processes and procedures that are performed by a physician, physician assistant, licensed nurse practitioner, emergency medical technician (EMT), paramedic or dentist. Diagnostic procedures are excluded unless further intervention beyond basic first aid is required.

(19) Reasonable Belief--A belief that would be held by an ordinary and prudent person in the same circumstances as the reporter.

(20) Report--Formal notification to the Commission of an allegation of abuse, neglect, exploitation or death or of serious incident.

(21) Reportable Injury--Any injury sustained by accidentally, intentionally, recklessly or otherwise that:

(A) Requires medical treatment; or

(B) Results from a personal, mechanical or chemical restraint and is a substantial injury.

(22) Serious Incident--Any incident that is an attempted escape, attempted suicide, escape, reportable injury, youth-on-youth physical assault or youth sexual conduct.

(23) Serious Physical Abuse--Bodily harm or condition that resulted directly or indirectly from the conduct that formed the basis of an allegation of abuse, neglect or exploitation, if the bodily harm or condition requires medical treatment.

(24) Sexual Abuse--Conduct committed by any person against a juvenile that includes sexual abuse by contact or sexual abuse by non-contact. A juvenile, regardless of age, may not affirmatively or impliedly consent to the acts as defined in paragraphs (25) and (26) of this section under any circumstances.

(25) Sexual Abuse by Contact--Any physical contact with a juvenile that includes: intentional touching of the genitalia, anus, groin, breast, inner thigh or buttocks with the intent to abuse, intimidate, hurt, humiliate or harass, arouse or gratify sexual desire; deviate sexual intercourse; sexual contact; sexual intercourse; or sexual performance as those terms are defined in subparagraphs (A) - (D) of this paragraph.

(A) "Deviate sexual intercourse" means:

(i) any contact between any part of the genitals of one person and the mouth or anus of another person; or

(ii) the penetration of the genitals or the anus of another person with a hand, finger or other object.

(B) "Sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(i) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a person; or

(ii) any touching of any part of the body of a person, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(C) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(D) "Sexual performance" means acts of a sexual or suggestive nature performed in front of one or more persons including simulated or actual sexual intercourse, deviate sexual intercourse, sexual bestiality, masturbation, sado-masochistic abuse or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.

(26) Sexual Abuse by Non-Contact--Any sexual behavior, conduct, harassment or actions other than those defined by sexual abuse by contact, which are exhibited, performed or simulated:

(A) in the presence of a juvenile or with reckless disregard for the presence of a juvenile;

(B) with the intent to arouse or gratify the sexual desire of any person;

(C) with the intent to intimidate, hurt, humiliate or harass any person;

(D) including repeated verbal statement or comments of a sexual nature; and

(E) including demeaning references to gender, derogatory comments about body or clothing or profane or obscene language or gestures.

(F) These behaviors, conduct and actions include indecent exposure, voyeurism, distribution or exhibition of pornographic or sexually explicit material or sexual performance as defined in paragraph (25)(D) of this section.

(27) Subject of Investigation--A person alleged as being responsible for the abuse, neglect or exploitation of a juvenile through the person's own actions or failure to act.

(28) Substantial Injury--An injury that is significant in size, amount or severity.

(29) Unfounded--The finding assigned to an internal investigation when the evidence indicates the conduct, which formed the basis of an allegation of abuse, neglect or exploitation, did not occur.

(30) Youth-on-Youth Physical Assault--A physical altercation between two or more juveniles that results in any of the involved parties sustaining an injury that requires medical treatment.

(31) Youth Sexual Conduct--Two or more juveniles, regardless of age, who engage in deviate sexual intercourse, sexual contact, sexual intercourse, sexual performance as those terms are defined in paragraph (25) of this section or sexual behavior, conduct or actions which are exhibited, performed or simulated as those terms are defined in paragraph (26) of this section. A juvenile may not consent to the acts as defined in paragraphs (25) and (26) of this section under any circumstances. Consent may not be implied regardless of the age of the juvenile.

§358.120. Interpretation.

(a) Headings. The headings in this chapter are for convenience only and are not intended as a guide to the interpretation of the standards in this chapter.

(b) Including. The word, "including" when following a general statement or term, is not to be construed as limiting the general statement or term to any specific item or manner set forth or to similar items or matters, but rather as permitting the general statement or term to refer also to all other items or matters that could reasonably fall within its broadest possible scope.

§358.140. Applicability.

Unless otherwise noted, these standards apply to all alleged incidents of abuse, neglect and exploitation, death and serious incidents involving a juvenile and an employee, intern, volunteer, contractor or service provider (hereafter referred to as "any person" or "all persons") in a juvenile probation department ("department"), juvenile justice program ("program") or juvenile justice facility ("facility"), regardless of the location of the alleged incident of abuse, neglect, exploitation, death or serious incident.

§358.200. Policy and Procedure.

Departments, programs and facilities shall have written policies and procedures for reporting serious incidents to the Commission and for reporting allegations of abuse, neglect and exploitation, including death to local law enforcement, the Commission and other appropriate governmental units.

§358.220. Data Collection.

(a) Departments, programs and facilities shall fully and promptly provide requested data pertinent to alleged incidents of abuse, neglect, exploitation, death and serious incidents to the Commission.

(b) The data shall be submitted in the electronic format requested or supplied by the Commission.

(c) The data shall include:

(1) Alleged victim(s) name;

(2) Alleged victim(s) PID;

(3) Name of subject(s) of investigation;

(4) Date of birth and Texas driver's license or state issued identification number of subject(s) of investigation;

(5) Date of incident;

(6) Time of incident;

(7) Date the incident was reported to the Commission;

(8) Type of incident (i.e., abuse, neglect or exploitation (ANE), death or serious incident (SI));

(9) Type of injury, if applicable;

(10) Restraint related, if so, what type (i.e., physical, mechanical or chemical);

(11) Disposition of internal investigation (i.e., Founded, Unfounded, Inconclusive); and

(12) County generated case identification number.

(d) The data shall be supplied at least annually or as required by Commission.

(e) The effective date of this section is September 1, 2009.

§358.300. Serious Incidents.

(a) Duty to Report. Any person who witnesses, learns of, receives an oral or written statement from a juvenile or other person with knowledge of or who has a reasonable belief as to the occurrence of a serious incident involving a juvenile shall report to the Commission.

(b) Time to Report. A report of a serious incident under subsection (a) of this section shall be made within 24 hours from the time a person gains knowledge of or suspects the serious incident occurred.

(c) Methods of Reporting Serious Incidents.

(1) The report shall be made by phone, or by faxing or e-mailing a completed Incident Report Form to the Commission.

(2) If the report is made by phone, a completed Incident Report Form shall be subsequently submitted to the Commission within 24 hours of the phone report.

§358.320. Medical Documentation for Serious Incidents.

A treatment discharge form or other medical documentation that contains evidence of medical treatment pertinent to the reported incident shall be submitted to the Commission within 24 hours of receipt.

§358.400. Abuse, Neglect and Exploitation.

(a) Duty to Report. Any person who witnesses, learns of, receives an oral or written statement from an alleged victim or other person with knowledge of or who has a reasonable belief as to the occurrence of an alleged incident of abuse, neglect or exploitation involving a juvenile shall report to the Commission and local law enforcement.

(b) Non-Delegation of Duty to Report. In accordance with Texas Family Code §261.101, the duty to report cannot be delegated to another person.

(c) Time to Report. A report of the alleged incident of abuse, neglect or exploitation under subsection (a) of this section, other than death and allegations involving serious physical abuse or sexual abuse, shall be made within 24 hours from the time a person gains knowledge of or suspects the alleged incident of abuse, neglect or exploitation.

(d) Methods for Reporting Abuse, Neglect and Exploitation.

(1) The report shall be made by phone, or by faxing or e-mailing a completed Incident Report Form to the Commission.

(2) If the report is made by phone, a completed Incident Report Form shall be subsequently submitted to the Commission within 24 hours of the phone report.

§358.420. Allegations Occurring Outside the Juvenile System.

Any person who witnesses, learns of, receives an oral or written statement from an alleged victim or other person with knowledge or who has a reasonable belief as to the occurrence of an alleged incident of abuse, neglect or exploitation involving a juvenile, but that is not alleged to involve an employee, intern, volunteer, contractor or service provider of a department, program or facility, shall be reported to law enforcement or to the appropriate governmental unit as required in Texas Family Code Chapter 261.

§358.440. Reporting of Allegations by Juveniles.

(a) Right to Report. Juveniles in a facility shall have the right to report to the Commission alleged incidents of abuse, neglect and exploitation, including death and allegations of serious physical abuse and sexual abuse.

(1) Juveniles shall be advised in writing during orientation into the facility of their right to report alleged incidents under this subsection; and

(2) Juveniles shall be advised in writing during orientation into the facility of the Commission's toll-free number available for reporting alleged incidents under this subsection.

(b) Policy and Procedure. Departments, programs and facilities shall have written policies and procedures that address a juvenile's reasonable, free and confidential access to the Commission for reporting alleged incidents under subsection (a) of this section.

(c) Access to the Commission. Upon the request of a juvenile, staff shall facilitate the juvenile's unimpeded access to the Commission to report alleged incidents under subsection (a) of this section.

§358.460. Parental Notification.

(a) Notification. Notification, or diligent efforts to notify, shall be made to the parents, guardians and custodians of a juvenile who

has died or who is the alleged victim of an alleged incident of abuse, neglect or exploitation, including allegations of serious physical abuse or sexual abuse.

(b) Time of Notification. The notification, or the diligent efforts to make the notification under subsection (a) of this section, shall be made as soon as possible, but no later than 24 hours from the time a person gains knowledge of or suspects the alleged abuse, neglect, exploitation or death occurred.

(c) Method of Notification. The notification under subsection (a) of this section shall be made by phone, in writing or in person by the administrator or designee.

(d) Documentation of Notification. The notification, or the diligent efforts to make the notification under subsection (a) of this section, shall be documented on the Commission's Incident Report Form or in the internal investigation report.

§358.480. Signage.

(a) Departments, programs and facilities shall prominently display signage provided by the Commission regarding a zero-tolerance policy concerning abuse of juveniles.

(b) Signage under subsection (a) of this section shall be posted in all of the following places:

(1) Lobby or visitation areas of the department, program or facility to which the public has access;

(2) Youth housing and common areas;

(3) Common medical treatment areas;

(4) Common educational areas; and

(5) Other common areas.

(c) Signage under subsection (a) of this section shall be posted in both English and Spanish.

§358.500. Serious Physical Abuse and Sexual Abuse.

(a) Duty to Report. Any person who witnesses, learns of, receives an oral or written statement from an alleged victim or other person with knowledge or who has a reasonable belief as to the occurrence of an alleged incident of serious physical abuse or sexual abuse involving a juvenile shall report to the Commission and local law enforcement.

(b) Time to Report.

(1) A report of alleged serious physical abuse or sexual abuse under subsection (a) of this section shall be made to local law enforcement immediately, but no later than one (1) hour from the time a person gains knowledge of or suspects the alleged serious physical abuse or sexual abuse; and

(2) A report of alleged serious physical abuse or sexual abuse under subsection (a) of this section shall be made to the Commission immediately, but no later than four (4) hours from the time a person gains knowledge of or suspects the alleged serious physical abuse or sexual abuse.

(c) Methods for Reporting Serious Physical Abuse and Sexual Abuse.

(1) The initial report shall be made by phone to law enforcement;

(2) The initial report shall be made by phone to the Commission using the toll-free number as designated by the Commission; and

(3) Within 24 hours of the report by phone of an alleged incident of serious physical abuse or sexual abuse, the completed Incident Report Form shall be submitted to the Commission by fax or e-mail.

§358.600. Death.

(a) Duty to Report. The administrator or designee shall report to the Commission and local law enforcement the death of a juvenile that occurs:

(1) On the premises of a department, program, facility; or

(2) Emanates from an illness, incident or injury that occurred on the premises of a department, program or facility; or

(3) Occurs while in the presence of a department, program or facility employee, intern, volunteer, contractor or service provider, regardless of the location.

(b) Time to Report.

(1) A report of a death shall be made to local law enforcement immediately, but no later than one (1) hour of the discovery or notification of the death; and

(2) A report of a death shall be made to the Commission immediately, but no later than four (4) hours from the discovery or notification of the death.

(c) Methods for Reporting Death.

(1) The initial report shall be made by phone to law enforcement;

(2) The initial report shall be made by phone or e-mail to the Commission using the toll-free number as designated by the Commission; and

(3) Within 24 hours of the report by phone of the death of a juvenile the completed Incident Report Form shall be submitted to the Commission by fax or e-mail.

§358.620. Custodial Death Investigation in a Facility.

Upon the death of a juvenile residing in a facility, the administrator shall:

(1) In accordance with Texas Code of Criminal Procedure Article 49.18(b) conduct an investigation of the death; and

(2) The investigation shall be conducted in accordance with §358.700 of this chapter.

§358.640. Custodial Death Investigation Report.

Upon the conclusion of the internal investigation of the custodial death of a juvenile in a facility, the administrator shall:

(1) In accordance with Texas Code of Criminal Procedure Article 49.18(b), file a written report of the cause of death with the state Attorney General no later than 30 days after the juvenile's death;

(2) Submit a copy of the death investigation report in paragraph (1) of this section to the Commission within 10 calendar days of completion; and

(3) Complete an internal investigation report in accordance with §358.800 of this chapter.

§358.660. Custodial Death Investigation in a Department or Program.

Upon the death of a juvenile in custody that occurs in a department or program as described under §358.600(a) of this chapter, the administrator or designee shall:

(1) Initiate an internal investigation in accordance with §358.700 of this chapter; and

(2) Upon the conclusion of the internal investigation, complete an internal investigation report in accordance with §358.800 of this chapter.

§358.680. Non-Custodial Death Investigation in a Department or Program.

Upon the death of a juvenile not in custody that occurs in a department or Program as described under §358.600(a) of this chapter, the administrator or designee shall:

(1) Initiate an internal investigation in accordance with §358.700 of this chapter; and

(2) Upon the conclusion of the internal investigation, complete an internal investigation report in accordance with §358.800 of this chapter.

§358.700. Internal Investigation.

(a) Investigation Requirement. An internal investigation shall be conducted by a person qualified by experience or training to conduct a comprehensive investigation in cases in which an incident of abuse, neglect, exploitation or death is alleged to have occurred. The effective date of this subsection shall be September 1, 2009.

(b) Policy and Procedure. Departments, programs and facilities shall have written policies and procedures for conducting internal investigations of allegations of abuse, neglect, exploitation and death.

(c) Conducting the Investigation. The internal investigation shall be conducted in accordance with the policies and procedures of the department, program or facility.

(d) Initiation of Investigation. The internal investigation shall be initiated immediately upon the administrator or designee gaining knowledge of the alleged abuse, neglect, exploitation or death. However, the initiation of the internal investigation shall be postponed if:

(1) Directed by law enforcement;

(2) Requested by the Commission; or

(3) Initiating the internal investigation compromises the integrity of a potential crime scene.

(e) Timeframe for Internal Investigation. The internal investigation shall be completed within 30 business days of the initial report to the Commission. The Commission may extend this timeframe upon request. If an extension is granted, the Commission may request submission of all information compiled to date or a statement of the status of the investigation.

§358.720. Reassignment or Administrative Leave During the Internal Investigation.

(a) Upon gaining knowledge of an alleged incident of abuse, neglect or exploitation, and until the finding of the internal investigation is determined, the administrator or designee shall immediately place on administrative leave or reassign to a position having no contact with the alleged victim, relatives of the alleged victim, or other juveniles, any person alleged to have abused, neglected or exploited a juvenile.

(b) If during the internal investigation the person(s) alleged to have abused, neglected or exploited a juvenile resigns or is terminated from employment, the Commission shall be notified no later than the second business day after the resignation or termination.

(c) If an individual under subsection (b) of this section obtains employment in another jurisdiction prior to the finding of the internal investigation being determined, the person(s) under investigation shall not be placed in a position having any contact with any juveniles until the disposition of the internal investigation is finalized in the county of previous employment.

§358.740. Written and Electronically Recorded Statements.

During the internal investigation, diligent efforts shall be made to obtain written or electronically recorded oral statements from all persons with direct knowledge of the alleged incident.

§358.760. Juvenile Board Responsibilities.

If the administrator is the person alleged to have abused, neglected or exploited a juvenile and the administrator is the highest ranking department, program or facility official, the juvenile board shall:

(1) Conduct the internal investigation in accordance with §358.700 of this chapter; or

(2) Appoint an individual to conduct the internal investigation in accordance with §358.700 of this chapter who is not one of the following:

(A) The person alleged to have abused, neglected or exploited a juvenile;

(B) A subordinate of the person alleged to have abused, neglected or exploited a juvenile; or

(C) A law enforcement officer currently acting in the capacity as a criminal investigator for the alleged incident of abuse, neglect, exploitation or death of a juvenile.

§358.780. Corrective Measures.

At the conclusion of the internal investigation, the governing board, the juvenile board, administrator or designee shall take appropriate corrective measures, if warranted, that may include, but are not limited to:

(1) A review of the policies and procedures pertinent to the alleged incident;

(2) Revision or modification of any policies or procedures as needed;

(3) Administrative disciplinary action or appropriate personnel actions against all persons found to have abused, neglected or exploited a juvenile; and

(4) The provision of additional training for all appropriate persons to ensure the safety of the juveniles, employees, interns, volunteers, contractors and service providers.

§358.800. Internal Investigation Report.

An internal investigation report shall be completed at the conclusion of all internal investigations resulting from an alleged incident of abuse, neglect, exploitation or death of a juvenile.

§358.820. Internal Investigation Report Components.

The internal investigation report shall include:

(1) The date the internal investigation was initiated;

(2) The date the internal investigation was completed;

(3) The date the alleged victim's parent, guardian or custodian was notified of the allegation, or documentation that diligent efforts to provide the notification were made;

(4) A summary of the original allegation;

(5) Relevant policies and procedures related to the incident;

(6) A summary or listing of the steps taken during the internal investigation;

(7) A written summary of the content of all oral interviews conducted;

(8) A listing of all evidence collected during the internal investigation, including all audio and/or video recordings, polygraph examinations, etc.;

(9) Relevant findings of the investigation that support the disposition;

(10) The assigned disposition of the internal investigation:

(A) Founded;

(B) Unfounded; or

(C) Inconclusive.

(11) The administrative disciplinary action or corrective measures taken to date, if applicable (e.g., termination, suspension, retrained, returned to duty or none, etc.);

(12) The date the internal investigation report was completed;

(13) The names of all persons who participated in conducting the internal investigation; and

(14) The name and signature of the person who submitted the internal investigation report.

§358.840. Submission of Internal Investigation Report.

(a) A copy of the internal investigation report shall be submitted to the Commission within five calendar days following its completion.

(b) The following documentation collected during the internal investigation shall be submitted to the Commission with the internal investigation report:

(1) Written statements;

(2) Relevant medical documentation, if the release is authorized by law;

(3) Training records, if applicable; and

(4) Any other documentation used to reach the disposition of the internal investigation.

§358.900. Cooperation with Commission Investigation.

(a) The juvenile board, administrator or designee shall fully and promptly cooperate with a Commission investigation of an alleged incident of abuse, neglect, exploitation or death of a juvenile by providing all evidence requested by the Commission in the format requested.

(b) All persons shall fully cooperate with any investigation of an alleged incident of abuse, neglect, exploitation or death of a juvenile.

(c) The juvenile board, administrator or designee shall make a diligent effort to identify and make available for questioning all persons with knowledge of the alleged incident of abuse, neglect, exploitation or death which is the subject of a Commission investigation.

§358.920. Redaction of Records.

(a) Request for Redaction. The subject of investigation may request that his or her identifying information be redacted from the Commission's records if:

(1) The Commission's final disposition of the case in which the subject of investigation was involved is "Ruled Out";

(2) The subject of investigation submits the request for redaction in writing to the Commission's Legal Division;

(3) The subject of investigation submits the request for redaction within 30 calendar days of the last day of the corresponding limitation period described in subsection (b) of this section;

(4) The subject of investigation has been continuously employed within the Texas juvenile justice system for the time period as specified in subsection (b) of this section; and

(5) The subject of investigation has not been named as the subject of investigation in a subsequent case of abuse, neglect or exploitation.

(b) Limitation Periods. A request for redaction may only be made if all requirements of subsection (a) of this section are met and if:

(1) Two years has expired from the date of the Commission's final disposition of "Ruled Out", and if, notwithstanding a violation of the Texas Administrative Code, the investigation of the alleged abuse, neglect or exploitation did not produce evidence of a violation of laws of this state or of the United States;

(2) Three years has expired from the date of the Commission's final disposition of "Ruled Out", if the allegation does not meet the elements of paragraph (1) or (3) of this subsection; or

(3) Five years has expired from the date of the Commission's final disposition of "Ruled Out", if the allegation involved serious physical abuse as defined by §358.100(23) of this chapter or sexual conduct as defined by §358.100(24) - (26) of this chapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900133
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: March 1, 2009
For further information, please call: (512) 424-6710

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WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 34. PUBLIC FINANCE

PART 11. OFFICE OF THE FIRE FIGHTERS' PENSION COMMISSIONER

CHAPTER 302. GENERAL PROVISIONS RELATING TO THE TEXAS EMERGENCY SERVICES RETIREMENT SYSTEM

34 TAC §302.6

Proposed new §302.6, published in the July 11, 2008, issue of the *Texas Register* (33 TexReg 5508), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900198

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE PROBATION COMMISSION

CHAPTER 344. EMPLOYMENT, CERTIFICATION AND TRAINING

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§344.100, 344.110, 344.120

The Texas Juvenile Probation Commission withdraws the proposed new §§344.100, 344.110, and 344.120 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6754).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900114
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER B. QUALIFICATIONS FOR EMPLOYMENT

37 TAC §§344.200, 344.210, 344.220, 344.230

The Texas Juvenile Probation Commission withdraws the proposed new §§344.200, 344.210, 344.220, and 344.230 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6755).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900115
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER C. CRIMINAL HISTORY SEARCHES

37 TAC §§344.300, 344.310, 344.320, 344.330, 344.340

The Texas Juvenile Probation Commission withdraws the proposed new §§344.300, 344.310, 344.320, 344.330, and 344.340 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6756).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900116
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER D. DISQUALIFYING CRIMINAL HISTORY

37 TAC §344.400, §344.410

The Texas Juvenile Probation Commission withdraws the proposed new §344.400 and §344.410 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6757).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900117
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER E. EDUCATION REQUIREMENTS FOR EMPLOYMENT AND CERTIFICATION

37 TAC §§344.500, 344.510, 344.520

The Texas Juvenile Probation Commission withdraws the proposed new §§344.500, 344.510, and 344.520 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6757).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900118
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER F. TRAINING AND CONTINUING EDUCATION

37 TAC §§344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.670, 344.680

The Texas Juvenile Probation Commission withdraws the proposed new §§344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.370, 344.680 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6758).

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TRD-200900119
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER G. COMPETENCY EXAMINATION

37 TAC §344.700

The Texas Juvenile Probation Commission withdraws the proposed new §344.700 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6760).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900120
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER H. CERTIFICATION

37 TAC §§344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, 344.890

The Texas Juvenile Probation Commission withdraws the proposed new §§344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, and 344.890 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6760).

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TRD-200900121
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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CHAPTER 350. INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§350.100, 350.110, 350.120, 350.200, 350.210, 350.220, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, 350.900 - 350.904

The Texas Juvenile Probation Commission withdraws the proposed new §§350.100, 350.110, 350.120, 350.200, 350.210, 350.220, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, and 350.900 - 350.904 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6762).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900130
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6718

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CHAPTER 358. IDENTIFYING, REPORTING AND INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460, 358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, 358.920

The Texas Juvenile Probation Commission withdraws the proposed new §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460, 358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, and 358.920 which appeared in the August 22, 2008, issue of the *Texas Register* (33 TexReg 6766).

Filed with the Office of the Secretary of State on January 12, 2009.

TRD-200900132
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 12, 2009
For further information, please call: (512) 424-6710

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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 12. COMMISSION ON STATE EMERGENCY COMMUNICATIONS

CHAPTER 251. REGIONAL PLANS--STANDARDS

The Commission on State Emergency Communications (CSEC) adopts the repeal and new §251.10, concerning the guidelines for implementing wireless E9-1-1 service, without changes to the proposed text as published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9833).

Repeal and adoption of new §251.10 is on account of the almost complete re-write of the existing section. The new section establishes updated guidelines for Regional Planning Commissions and Wireless Service Providers to follow in implementing and providing wireless E9-1-1 service.

No comments were received regarding the repeal and adoption of new §251.10.

1 TAC §251.10

The section is repealed pursuant to Health and Safety Code §§771.051, 771.055, 771.056, 771.057, 771.061, 771.075, 771.0751, 771.078, and 771.079.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900191
Patrick Tyler
General Counsel
Commission on State Emergency Communications
Effective date: February 3, 2009
Proposal publication date: December 5, 2008
For further information, please call: (512) 305-6930

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1 TAC §251.10

The new section is adopted pursuant to Health and Safety Code §§771.051, 771.055, 771.056, 771.057, 771.061, 771.075, 771.0751, 771.078, and 771.079.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900187
Patrick Tyler
General Counsel
Commission on State Emergency Communications
Effective date: February 3, 2009
Proposal publication date: December 5, 2008
For further information, please call: (512) 305-6930

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1 TAC §251.14

The Commission on State Emergency Communications (CSEC) adopts the repeal of §251.14, concerning general provisions and definitions. The repeal is adopted without changes to the proposal as published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9834).

The repeal of §251.14 is concomitant with the adoption of new §252.7, concerning Definitions. By repealing §251.14 and adopting it as new §252.7 in Chapter 252, relating to Administration, CSEC makes clear the general applicability of the defined terms.

No comments were received regarding the repeal of §251.14.

The repeal is adopted pursuant to the Health and Safety Code, Chapter 771, §§771.051, 771.055, 771.056, 771.057, 771.071, 771.072, 771.075, 771.0751, 771.079; which authorize the Commission to plan, develop, fund, and provide provisions for the enhancement of effective and efficient 9-1-1 service.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900190
Patrick Tyler
General Counsel
Commission on State Emergency Communications
Effective date: February 3, 2009
Proposal publication date: December 5, 2008
For further information, please call: (512) 305-6930

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CHAPTER 252. ADMINISTRATION

1 TAC §252.7

The Commission on State Emergency Communications (CSEC) adopts new §252.7, concerning the definition of common terms used by CSEC, without changes to the proposed text as published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9835).

Adoption of new §252.7 is concomitant with the repeal of §251.14, *General Provisions and Definitions.* By adopting new §252.7 and repealing §251.14, CSEC makes clear the general applicability of the defined terms.

No comments were received regarding proposed new §252.7.

The new section is adopted pursuant to Health and Safety Code §§771.051, 771.055, 771.056, 771.057, 771.061, 771.075, 771.0751, 771.078, 771.079.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900188
Patrick Tyler
General Counsel
Commission on State Emergency Communications
Effective date: February 3, 2009
Proposal publication date: December 5, 2008
For further information, please call: (512) 305-6930

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TITLE 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 8. PIPELINE SAFETY REGULATIONS

The Commission adopts amendments, in Subchapter A, to §8.5, relating to Definitions; in Subchapter B, adopts amendments to §8.115 and new §8.135, relating to New Construction Commencement Report and Penalty Guidelines for Pipeline Safety Violations; in Subchapter C, adopts amendments to §§8.203, 8.205, 8.210, 8.215, 8.225, 8.230, and 8.235, relating to Supplemental Regulations; Written Procedure for Handling Natural Gas Leak Complaints; Reports; Odorization of Gas; Plastic Pipe Requirements; School Piping Testing; and Natural Gas Pipelines Public Education and Liaison; and, in Subchapter D, adopts amendments to §§8.301, 8.305, 8.310, and 8.315, relating to Required Records and Reporting; Corrosion Control Requirements; Hazardous Liquids and Carbon Dioxide Pipelines Public Education and Liaison; and Hazardous Liquids and Carbon Dioxide Pipelines or Pipeline Facilities Located Within 1,000 Feet of a Public School Building or Facility. The amendments in §§8.205, 8.210, 8.215, and 8.301 and new rule §8.135 are adopted with changes to the proposed versions published in the October 10, 2008, issue of the *Texas Register* (33 TexReg 8461); the amendments in §§8.5, 8.115, 8.203, 8.225, 8.230, 8.235, 8.305, 8.310, and 8.315 are adopted without changes to the proposed versions. The effective date of the amendments and new rule will be February 4, 2009.

The Commission adopts the amendments and new rule to provide guidelines for filing required reports with the Commission, to address new risk management initiatives for the Commission's pipeline safety evaluation program, and to remove outdated or duplicative rule requirements.

The Commission received comments from ten entities. Five groups or associations submitted comments: Texas Pipeline Association ("TPA"); Texas Independent Producers and Royalty Owners ("TIPRO"); Texas Oil and Gas Association ("TxOGA"); Permian Basin Petroleum Association ("PBPA"); and Texas Coalition of Cities for Utility Issues ("TCCFUI"), whose member cities are Abernathy, Addison, Alamo, Allen, Andrews, Arlington, Balcones Heights, Belton, Benbrook, Big Spring, Bowie, Breckenridge, Brenham, Brookside Village, Brownfield, Brownwood, Buffalo, Canyon, Carrollton, Cedar Hill, Center, Cleburne, Conroe, Corinth, Corpus Christi, Cottonwood Shores, Crockett, Dallas, Denison, Denton, Dickinson, El Lago, Electra, Euless, Fairview, Flower Mound, Fort Worth Fredericksburg, Friendswood, Frisco, Galveston, Grand Prairie, Grapevine, Greenville, Gregory, Henrietta, Huntsville, Irving, La Grange, La Joya, Lampasas, Lancaster, Laredo, League City, Leon Valley, Levelland, Lewisville, Longview, Los Fresnos, Mansfield, McAllen, Midlothian, Missouri City, Newark, Nolanville, North Richland Hills, Oak Point, Palacios, Pampa, Paris, Pearsall, Plainview, Plano, Port Neches, Ralls, Refugio, Reno, Richardson, River Oaks, Rosenberg, San Jacinto City, San Marcos, San Saba, Selma, Seminole, Seymour, Smithville, Snyder, South Padre Island, Spearman, Stephenville, Sugar Land, Sunset Valley, Sweeny, Taylor Lake Village, Terrell, Thompsons, Timpson, Trophy Club, Tyler, University Park, Vernon, Victoria, Waxahachie, Webster, West University Place, and Westlake. Other comments were submitted by Atmos Energy Corporation ("Atmos Energy"); CenterPoint Energy Arkla, CenterPoint Energy Entex and CenterPoint Energy Intrastate Pipeline, Inc. (collectively "CenterPoint"); Texas Gas Service ("TGS"); CPS Energy; and one individual.

TPA stated that it appreciates the Commission's efforts to clarify the issues identified last year.

TIPRO commented that it understands the purpose of the proposed changes is to implement new federal regulations governing persons owning or operating pipelines in Texas. By adopting the federal regulation by reference, rules covering pipeline safety in Texas would conform to federal requirements. These rules should be no more or no less stringent than the federal rules. TIPRO agrees with that effort, and with the Commission's authority to regulate all common carrier and common purchaser pipelines in Texas.

PBPA stated its full support of the comments provided by TxOGA regarding these proposed rule changes.

TCCFUI stated that, overall, the rules provide a positive revision to the Commission's pipeline safety rules. It is critical to the safety of the general public, and in particular the populations of urban areas, that the Commission continue to examine and amend its pipeline safety rules to put in place a regime that is comprehensive and consistent with federal law, yet efficient in its implementation. Given the increasing production of natural gas in densely populated areas, such as in the Barnett Shale, it is indeed imperative that the Commission update its pipeline safety rules to create orderly and effective mechanisms to handle penalties for violations, leak complaints, and odorization issues with respect to natural gas lines. Public awareness regarding natural gas pipelines is also an important component to pipeline

safety, both through public education and public notice. TCCFUI stated that the proposed rules represent an excellent step in this direction.

CenterPoint stated its general support of the goal of updating the state rules to achieve consistency with their federal counterparts, and acknowledged that the Commission has both the right and a policy imperative to amplify upon the federal rules and enact stricter rules governing intrastate pipelines in areas such as incident reporting and odorization. Most of CenterPoint's comments seek clarification of the proposed rules and the Commission's intent behind them.

TGS stated its support of the efforts of the Commission to clarify the rules and increase safety within the industry. TGS supports the concepts contained in the proposed Chapter 8 rules.

CPS Energy agreed with a vast majority of the proposed Chapter 8 rule changes, but recommends that the Commission consider its specific suggested changes to §8.205 and §8.210.

Regarding the proposed amendment of the definition of the term "transportation of gas" in §8.5(28), TIPRO sought to clarify the use of the phrase "production facilities." This section of the rule concerns definitions applicable to pipelines covered by the Commission's proposal. Again, TIPRO commented, if the Commission intends to adopt the federal rules by reference and not expand the coverage of the rules, TIPRO agrees with that effort. However, TIPRO believes the inclusion of "production" expands the scope of the federal rules. TIPRO seeks clarification to determine if that expansion is intended. In response, the Commission affirms its intent that the rules will apply to production facilities, as set forth in foregoing paragraphs.

In §8.115, the Commission proposed to clarify the requirements for filing a new construction report and to specify that the requirement applies to liquefied petroleum gas distribution systems. TCCFUI supports the Commission's proposed amendments to §8.115, but recommends additional changes that, in TCCFUI's view, do not attempt to remove the Commission's amendments, but instead seek to improve on the quality of information provided by natural gas pipeline operators to the Commission and to increase public awareness of the construction and installation of natural gas pipelines within the certain portions of the corporate limits of a municipality, prior to construction. Specifically, TCCFUI would require that the pre-construction reports also identify public streets, right-of-ways, and alleys to be traversed that are located with the corporate limits of a municipality, if any, and that each operator filing a Form PS-48 report for the construction of a natural gas pipeline with the Commission in accordance with this rule also submit a copy of that report with every municipality, through its City Manager, that has a public street, right-of-way, or alley that is proposed to be traversed by such pipe, at least 30 days prior to commencement of construction of that pipe.

In support of its suggested additional requirements, TCCFUI's stated that although its proposed changes to §8.115 would require the Commission to add a line item to Form PS-48 requesting the streets, rights-of-way, and alleys traversed within the corporate limits of a municipality, the modifications do not place a greater burden on the Commission on a day-to-day basis. Additionally, the impact of these changes to operators is minimal. With these offered changes, TCCFUI stated, operators would be required to provide the Commission with the public streets, right-of-ways, and alleys within the corporate limits of a municipality that would be crossed by the proposed pipe route, and to provide a copy of Form PS-48 to that municipality. TCCFUI further asserted that the Commission has jurisdiction to incorporate these changes into §8.115 in this rulemaking. As noted in the Commission's discussion of the changes proposed for Chapter 8, Subchapter B, Texas Natural Resources Code §81.051 and §81.052, grants the Commission with jurisdiction over all common carrier pipelines, persons owning or operating pipelines in Texas, and authorizes the Commission to adopt all necessary rules for governing and regulating persons and their operations. In addition to this general authority, TCCFUI notes, Texas Utilities Code, §§121.201 - 121.210, authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and for associated pipeline facilities. In particular, Texas Utilities Code, §121.2015, requires the Commission to adopt rules regarding public education and awareness of gas pipeline facilities. TCCFUI's argues that its proposed changes further public education and awareness, through municipal notice, regarding the location of new pipes that will be constructed within that city's corporate limits. Providing such information to municipalities, and thus, their citizenry, prior to construction will promote public safety and facilitate the construction of pipes within the corporate limits of a municipality. A municipality has an interest in being notified of the potential construction of any new natural gas pipelines within its city limits, prior to the initiation of construction. But for providing a municipality with a copy of Form PS-48, TCCFUI avers, a municipality may not otherwise be aware of the installation of a new pipeline. For example, under the Underground Facility Damage Prevention and Safety Act, Texas Utilities Code, Chapter 251, municipalities are not required to participate in the Texas One Call system. Further, water and sewer utility lines, designated as "Class B underground facilities," are not required to participate in a one-call notification center operation. *See* Texas Utilities Code, §121.107, which requires each operator of a Class A underground facility, including a political subdivision of this state, to participate in a notification center as a condition of doing business in this state. Thus, providing a municipality with the proposed pipe route through that city, prior to construction, could minimize the potential for rupturing water and wastewater utility lines that are already in place, as a pipeline operator may not be aware of the location of such utility lines. The Underground Facility Damage Prevention and Safety Act recognizes this possibility, as Texas Utilities Code, §251.153(a), places the duty on a One Call notification center, at the time an excavator provides a notification center with the excavator's intent to excavate, to advise the excavator that water, slurry, and sewage underground facilities in the area of the proposed excavation may not receive information concerning the excavator's proposed excavation. Thus, by providing municipalities with a copy of Form PS-48 prior to construction could reduce the likelihood and costs associated with repairing a ruptured line. In conclusion, TCCFUI noted that the Commission has done an exceptional job of following through on its proposed changes from 2007, incorporating subsequent public comment regarding pipeline safety. In these comments, TCCFUI seeks to add value to the hard work that has been put forth to date, and to offer additional changes to §8.115 that will not unduly burden the Commission, but instead inform the public of new pipeline construction initiatives within urban areas.

The Commission recognizes that, under the statutory provisions cited by TCCFUI, the Commission has the authority to impose the requirements suggested by TCCFUI, and that such additional requirements would be an efficient way of notifying many public entities of imminent pipeline construction. However, under Texas Government Code, Chapter 2001, state agencies must give notice of their intent to amend rules, and one of the require-

ments is to specifically identify the proposed wording changes. With respect to making changes upon the adoption of a proposed rule, the Third Court of Appeals wrote: " . . . should the proposed rules, as originally published, be ignored and others adopted *or should other subjects or persons be affected by the altered rule,* a new round of notice and comment should be required." (Emphasis added.) *State Bd. of Ins. v. Deffebach,* 631 S.W.2d 794, Tex. App. 3 Dist., 1982. The Commission has determined that, despite the reasonableness and efficiency of TCCFUI's suggested changes, the scope of notice in this rulemaking would not permit their inclusion. In the meantime, a municipality likely has the authority to require by city ordinance that a pipeline operator filing with the Railroad Commission a Form PS-48 showing a municipal street, right-of-way, or alley that is proposed to be traversed by a new pipeline also submit a copy of that report with the municipality's City Manager at least 30 days prior to commencement of construction of that pipeline.

TPA expressed no objection to the Commission proposal in §8.115, but requested that the Commission staff work with industry representatives to streamline the construction notification process after the rule adoption. Because of significant activity in certain areas of the state, both operators and the Commission should have a process that maximizes the efficiency of the reporting process as well as guarantees the accuracy of the information being required and submitted. The current process places a significant burden on both the industry and the Commission for a number of reasons and does not accomplish the goals of the Commission. Because TPA did not offer specific criticisms of the ways in which the process is claimed to burden industry and the Commission, identify the ways in which the Commission's goals are not being met, or offer suggestions for changing the process that would not need to be part of the rule, the Commission is unable to respond to this comment.

TxOGA commented that while the wording does not specify production operations, TxOGA understands the Commission's intent to be that this provision will apply to regulated production operations as well, which means that the Commission's advance reporting requirement for gas pipelines is more stringent than federal or adjoining state requirements. TxOGA recommends that aligning the gas pipeline pre-construction notice requirements in the Texas regulations with those in the federal regulations and in some other major oil and gas states be considered by the Commission in a future pipeline safety rulemaking and that, if necessary, the Commission convene a workgroup to develop a specific recommendation in this regard. The Commission confirms its intent that the pre-construction notice requirements apply to production operations.

With respect to new §8.135, relating to Penalty Guidelines for Pipeline Safety Violations, TPA commented that it does not object to the proposal; however, TPA requests that the Commission further review how repeat or multiple violations impact operators, and, more specifically, when the violations are by different operational units or areas. This can be highlighted especially by those penalized under the damage prevention safety rules in Chapter 18 (relating to Underground Pipeline Damage Prevention). Larger operators have an inherent disadvantage in that they have a great exposure to increased penalty enhancement because of significantly more one-call tickets due to more miles of pipeline. A strong argument can be made that a large pipeline operator receiving tens-of-thousands of one-call tickets should not be penalized in the same manner as an operator who only receives 50 locate tickets per year.

TxOGA commented that the consolidation of gas and hazardous liquid pipeline penalty guidelines in §8.135 is not intended to change the current guidelines, but expressed an issue with regard to the current guideline. The "penalty enhancement" section provides for increased penalties for repeat offenders. TxOGA does not dispute the necessity of such penalty enhancement in some cases, but notes that there is no provision for consideration of such offenses on a regional basis for an operator with statewide operations. TxOGA recommends that such a refinement of the penalty enhancement provision for repeat offenders be considered by the Commission in a future pipeline safety rulemaking and that, if necessary, the Commission convene a workgroup to develop a specific recommendation in this regard.

The Commission neither agrees nor disagrees with these comments regarding enforcement policy for repeat or multiple violations; moving this rule from the subchapter devoted to natural gas pipelines to the subchapter applicable to all pipelines was intended to ensure that the Commission's penalty guidelines were administered equitably with respect to both natural gas pipelines and hazardous liquids and carbon dioxide pipelines.

The Commission received numerous comments regarding the proposed amendments in §8.205(3) that would require that the supervisory review of leak complaints be completed and documented by 10:00 a.m. each day for calls received by midnight on the previous day. CenterPoint stated that while it understands the need for a second level of review of leak response, using specially trained personnel with the requisite authority to require remedial action would achieve the same results. CenterPoint recommends that the rule allow this review to be conducted by such specially trained personnel, and that the rule also allow the review to be conducted by the next work day rather than the next calendar day.

Atmos Energy acknowledged that the proposed rule reflects recognition of the continuous operational aspects of natural gas distribution systems. Atmos Energy submits, however, that the rule should be modified to allow for review of the leak reports by 10 a.m. of the following business day as opposed to the proposed review by 10 a.m. of the following day. Additionally, Atmos Energy suggests that the "supervisory review" terminology be modified to more clearly establish that it is appropriate for experienced personnel who are not supervisors to perform this review.

CPS Energy recommends that §8.205(3) state that a trained person *(i.e.,* a dispatcher or other qualified employee) may perform the review of all leak complaints. The current language implies that only a supervisor may perform the review of leak complaints for a gas operator. CPS Energy believes the proposed regulation places an unnecessary burden on its supervisors to perform this requirement 365 days a year when there are other trained and qualified individuals who are also capable of performing this function.

TGS suggests that the proposed rule be amended as follows: "a requirement that a review of leak complaints by trained personnel must be completed and documented by 10:00 a. m. each day for calls received by midnight on the previous day."

TPA suggested during the initial rulemaking that the establishment of a specific time for completion of supervisory reviews of leak complaints is appropriate, and the Commission should be commended for establishing a deadline. However, in light of the possibility that leak complaints could be called in on the day before a holiday or weekend or during a weekend, the deadline for

supervisory review should be set at 10:00 of the next business day. This slight change will accommodate the delays inherent in the scheduling of work for weekends and holidays.

The Commission disagrees with some of these comments. The purpose of the proposal is to ensure that if a leak is hazardous, it is being addressed. Human review is necessary to determine if the leak has been graded properly, and the review should be conducted by someone with authority, not just knowledge, in case the leak grade needs to be changed. The requirement that the review be conducted by a supervisor was already in §8.205(3) and was not proposed to be changed. With respect to the timing of the review, however, the Commission agrees that it is reasonable to change the wording as it was proposed to allow the deadline to be 10:00 a.m. of the next business day.

Regarding the proposed amendment to §8.210(a)(1), CenterPoint stated that it supports the use of the federal criteria for incident reporting and the concomitant elimination of the current duplicative incident reporting regime. In particular, it should allow operators to utilize their experience under the federal regime to determine when an incident is significant in light of its severity and relative effect on the communities in which they operate. However, CenterPoint commented that the Commission also proposes some more troublesome changes to other parts of the regulation. In §8.210(a)(2)(F), the proposed requirement that the telephonic report include the telephone number of the operator's on-site person, CenterPoint commented that, in almost all cases, the crew responding to a gas-related incident will be acting as first responders, not as trained fire investigators or insurance adjusters who can accurately render damage estimates or opine about the cause and origin of the incident. These employees' first tasks are to make the area safe, protect life and property, and then conduct certain tests. Needless to say, the first few hours after an incident can be chaotic and dangerous. The crew may be hard pressed to accomplish even the basic tasks of protecting life, property, and the integrity of the system during that time period. In addition, many crews do not carry a mobile telephone and thus communicate to their respective offices by radio only. It would be more helpful and appropriate for the Commission to contact the crew's supervisor or another local company representative during those critical first hours after an incident. Thus, CenterPoint suggests that proposed subsection (a)(2)(F) be changed to require only the telephone number of a contact person rather than the number of an on-site employee. Atmos Energy commented that while Atmos Energy is not opposed to providing the Commission with the telephone number of on-site personnel, Atmos Energy stresses that the work priority for on-site personnel is making the situation safe, not responding to telephone inquiries. The Commission appreciates that the primary obligations of gas company first-responders is to deal with emergent events. However, having the telephone number of the operator's on-site person assists the Railroad Commission staff in determining whether the Commission need to go on-site, whereas contacting a crew supervisor or other local company representative would not provide the Commission with specific data regarding the conditions at the incident site. The rule allows an operator two hours to make the telephonic report, so this should permit sufficient time for making the telephone call and providing the information necessary for the Commission to fulfill its obligations.

Several entities commented on the proposal to add subparagraph (G) in §8.210(a)(2), requiring a report of the estimated property damage, including the cost of gas lost, to the operator, others, or both. CenterPoint stated that an accurate estimate of the damage (other than that required to determine whether the incident is reportable) may be impossible during the first day after an incident. For example, the amount of gas lost cannot be accurately measured until the time of the rupture and the size of the hole are determined. The damage estimate requirement should also await the written report due 30 days after the incident. Atmos Energy stated that it is not opposed to providing an estimate of property damage at the time the telephonic report is made, but stated that the estimate will be very rough, at best. TPA has no objection to the requirement to report estimated damage with the telephonic report, however, deleting this provision would make the natural gas reporting requirements consistent with the requirements found under the reporting requirements for hazardous materials and carbon dioxide pipelines in §8.301. If the damage estimate provision remains in the final rule, TPA wants to be certain that the Commission is aware that any such estimates will be very rough. Accurate estimates of property damage cannot be made until after the investigation is competed and the extent of necessary repairs is determined. The Commission agrees that the initial estimates will necessarily be very rough, but is interested primarily in knowing whether the damage is over or under $50,000. Under the definition of "incident" in 49 CFR §191.3, if an operator is calling to report a release in which there is no death or injury and no media involvement, then the call is being made because the estimated property damage is $50,000 or more. Further, the requirement to make an estimate of property damage in the initial telephonic report is not new; only the amount has been changed (increased from $5,000 to $50,000).

The Commission proposed to amend §8.210(a)(2)(H) to add examples of significant facts that should be reported. Ignition, explosion, rerouting of traffic, evacuation of any building, and media interest are included as significant facts relevant to the accident or incident. Atmos Energy commented that it is uncertain if "significant facts" are distinguishable from "significant events" which cause an event to become a reportable event even if no injury occurs and the stated property damage threshold is not met. As an example, the evacuation of any building is listed as a "significant fact." If "building" means "structure" which would include a residence, then the evacuation of a single residence becomes a "significant fact" which should be included in the telephonic report if the incident is reportable for other criteria reasons. On the other hand, if the "significant fact" of a single residence evacuation is equated with a "significant event," then all evacuations become reportable events which will cause a spike in every operator's telephonic reports. Atmos Energy suggests that the Commission clarify its intent to distinguish between "significant events" and "significant facts." TPA commented that the inclusion of the evacuation of any building as a significant fact to be included in the telephonic report places a classification of "significant" on single home evacuations. While those evacuations will be significant to the individual residents of a home, reporting such information will not contribute meaningfully to pipeline safety data. It would seem to be more beneficial to gather data related to evacuations impacting larger numbers of individuals, such as schools or commercial buildings, and TPA would suggest that such an addition be made to this particular reporting requirement. The Commission disagrees with comments that interpret this proposal as converting an otherwise unreportable incident into a reportable incident. The requirement to include "other significant facts" in a telephonic report is not new; the only change is to add examples of facts that are significant enough to be reported if a report is necessary. An incident that would not be reportable under the standards in §8.210(a)(1) does not become reportable just because of a "significant fact," such as

ignition, explosion, rerouting of traffic, evacuation of any building, or media interest. The significant fact is simply additional information to be reported.

The proposal to add new subsection (e), relating to leak reporting, to §8.210, garnered extensive comments. CenterPoint commented that the new reporting mechanism would apparently require operators to enter 27 different items of information about each leak and, while the preamble to the rules suggest that an electronic data interchange system will allow the transmission of the required data by spreadsheet, it is still likely that errors will occur that will require manual entry or at least correction. For a large operator such as CenterPoint that experiences thousands of leaks in a 6 month period, it would be administratively burdensome to correct or verify the potentially thousands of pieces of information contained in these semi-annual reports. CenterPoint believes that this new report is unnecessary since the Commission already has the right to audit leak records under current law. However, if the Commission still desires to implement this new reporting requirement, CenterPoint suggests that a summary of the types of leaks encountered on its system would be a more efficient and equally informative method of gathering the information that the Commission seeks. Instead of entering the information for each particular leak, an operator could provide a total for each category of information for all leaks it experienced during the reporting period. If the Commission requires more information, it would be able to audit behind these numbers to obtain this data as well as insure its accuracy. Finally, the reference to an operator's "pipeline system" does not make it clear whether the report must include leaks on non-jurisdictional facilities (such as customer house piping) as well as those on the operator's pipeline facilities. Such leaks are not required to be monitored under Commission rules nor are they presently included in the annual report required by 49 CFR §191.11. In order to resolve this ambiguity, CenterPoint suggests the subsection be amended to refer to leaks on "pipeline facilities" so as to incorporate the corresponding definition already contained in §8.5.

Atmos Energy commented that the information required to be reported is already available to the Commission and requiring the information to be provided in the online format is duplicative. Further, in the event the semi-annual reporting requirement is adopted, Atmos Energy submits that the rule should be revised to allow for a reasonable period of time between the end of the semi-annual period and the online reporting due date for the leak information. Also, the online reporting should be specifically directed to below ground leaks.

CPS Energy recommends that Form PS-95 be required to be filled out for below ground leaks for only the following reasons:

1. below ground leaks are what present a potential danger to the public;

2. CPS Energy's experience at capturing the data on above ground leaks has shown that they are typically on threaded connections, non-hazardous, and do not present a danger to the public due to the extremely small quantities of gas that is vented to atmosphere from these leaks;

3. according to the instructions for completing the PHMSA Annual Reports for Distribution or Transmission systems; Forms F 7100.1-1 and F 7100.2-1, a non-hazardous release of gas that can be eliminated by lubrication, adjustment or tightening is not defined as a leak. Since most aboveground leaks can be eliminated by lubrication, adjustment or tightening, CPS Energy feels that these should not be included in the proposed reporting requirements;

4. many gas operators do not currently report or grade above ground leaks;

5. the number of above ground leaks repaired is far greater than the number of below ground leaks repaired and will require a substantial amount of time to collect and input the data into the PS-95 on-line form; and

6. little value will be realized by capturing the data for above ground leaks when compared to the time and expense required to collect and input the data.

TGS believes the detail that is required to be reported is burdensome and will require expensive modifications to our existing processes and software programs. TGS can comply with semi-annual reports with less detail on the seven items listed out in the proposed rule without an appreciable increase in costs. This can be accomplished if the report will aggregate the items similar to the OPS Annual Gas Distribution Report twice a year without the specific detail requirements on each leak. As proposed, the detail required also appears to be in conflict with the OPS definitions of what is considered a leak. As defined in the instructions of PHMSA F 7100.1-1 form, "A leak is defined as an unintentional escape of gas from the pipeline. A non-hazardous release that can be eliminated by lubrication, adjustment, or tightening, is not a leak." Based upon this definition, there seems to be a difference in the proposed rule and the PHMSA rules which will create confusion in reporting and data analysis between PHMSA and the State of Texas. If these changes cannot be implemented, then TGS requests a workshop be conducted to review this proposed rule change with industry to determine if some changes can be accomplished.

TPA commented that the final rule is unclear as to whether the reporting requirement only applies to local distribution company (LDC) operators as it states in the preamble of the rule. TPA requests the Commission clarify in the final rule that the semi-annual reporting requirement only applies to LDCs. Midstream pipeline operators are required to report leaks that meet the requirements of 49 CFR 191.3 to the Commission. Further, leaks are repaired. Pipeline operators do not have the same types of leaks, nor leak grading system or repair schedule in comparison with the LDCs.

TxOGA commented that the leak reporting requirements proposed in §8.210(e), as drafted, appear to apply to all operators of pipelines, and possibly even to production facility operators. The Commission's impact analysis for this portion of the proposal speaks only of the cost to gas distribution companies. TxOGA now understands that it is the intent of the Commission that this section of the proposal apply only to gas distribution companies and to operators of plastic gas transmission lines. TxOGA concurs with this limitation on the regulation and recommends adding the italicized wording to clarify the requirement: (e) Leak Reporting. Each operator *of a gas distribution system or plastic gas transmission line* shall submit to the Division a list of all leaks repaired on its pipeline systems. The report shall list all leaks identified on the entire pipeline system. Each *such* operator shall also include the number of unrepaired leaks remaining on the operator's systems by leak grade. Each *such* operator shall submit leak reports using the Commission's online reporting system, Form PS-95, by June 30 and December 31 of each calendar year, in accordance with the PS-95 Semi-Annual Leak

Report Electronic Filing Requirements, set out in Figure 1 of this subsection. The report includes:..."

The Commission agrees that the term "pipeline facilities" is preferable to the term "pipeline systems," and has made that change in the text of the adopted rule. The Commission disagrees that having leak information available to audit is sufficient. The purpose of the reporting requirement is to enable the Commission to accumulate data from across all systems to identify trends or problems more comprehensively. The Commission also disagrees that operators would be unable to correct data already reported; that will be possible on the online reporting system. The Commission agrees that a non-hazardous release of gas that can be eliminated by lubrication, adjustment, or tightening is not defined as a leak; however, there are other above ground leaks that cannot be eliminated using these methods, and those must be reported as leaks. The Commission adopts §8.210(e) with clarifying wording regarding the definition of the term "leak" for the purpose of submitting the Form PS-95. The Commission also agrees that, because this rulemaking includes the elimination of the plastic pipe failure report, this rule must include information about any leak on any plastic pipe, not just distribution plastic pipe. The leak reporting requirements apply to operators of local gas distribution companies, operators of regulated plastic gas gathering lines, and operators of plastic gas transmission lines, and the Commission has modified the wording in §8.210(e) to clarify this intent.

Regarding the proposal to amend §8.215(b) to permit gas companies to use commercially available odorization equipment rather than having the Commission approve odorization equipment, CenterPoint commented that while this change avoids having the Commission rule on "permissible" odorizers and odorants, the term "commercially available" does not necessarily equate to satisfactory performance. In particular, the fact that equipment is commercially available would not guarantee that a product meets the performance criteria that would still be required under the rule. A more prudent approach would be to require "industry accepted" or "industry standard" equipment. In addition, CenterPoint requests that the rule contain a "grandfather" clause that would provide that all previously approved or currently used equipment would meet the standards established under the rule. Atmos Energy commented that the use of any existing shop-made odorization equipment should be grandfathered for a reasonable period of time. TPA seeks to clarify that non-commercial odorization equipment already in place, which has been approved by the Commission, may continue to be used by operators. TxOGA understands that it was not the intent of the Commission to disallow continued use of previously approved odorization devices and recommends the following italicized language to clarify that intent: (b) Odorization equipment. Gas companies shall use commercially available odorization equipment *in any installation made on or after (the effective date of this rule). Shop-made or other odorization equipment previously approved by the Commission and in use as of (the effective date of this rule) may continue to be used in its current service, but may not be re-installed in a different location.*

The Commission disagrees that substituting "industry standard" would be a more prudent standard than the proposed "commercially available." The proposed change shifts the burden of selecting odorization equipment that meets the performance standards of the rule. These are management decisions properly left to each operator. The Commission disagrees that a rule with prospective effect only could invalidate existing use of shop-made odorization equipment, but does not object to adding the wording suggested by TxOGA, but has substituted "February 4, 2009," for "the effective date of this rule" to clarify the requirement.

In §8.235(a), the Commission proposed to change deadline by which operators of natural gas pipelines or natural gas pipeline facilities are required to communicate and conduct liaison activities fire, police, and other appropriate public emergency response officials. Currently the requirement is that these activities are to be conducted on an annual basis; the Commission proposed to amend the deadline to once each calendar year at intervals not exceeding 15 months. Atmos Energy commented that because of the hierarchical requirements of the Commission's rule (face-to-face meeting attempts followed by attempts to schedule a conference call and then mailing the information by certified mail) in the event the annually scheduled meeting does not take place, it will be difficult to accomplish all of the ensuing actions in a three month window. Atmos Energy submits that the proposed rule should be revised to provide for the initial face-to-face meeting request to be made once each calendar year at intervals not exceeding fifteen months from the date of the completion of the last liaison activity with that emergency responder, with any subsequent liaison activity to be accomplished by the end of the calendar year. The Commission disagrees with this comment. The intent of the current rule is that operators conduct these liaison activities once a year, but some operators would allow an interval of as long as 23 months between such meetings, *e.g.,* January of one year but not until December of the following year, nearly a two-year lapse. The Commission acknowledges that it can take some time and effort to set up the meetings or conference calls, but there is nothing in the rule that prohibits an operator from beginning the efforts at the nine or ten month interval to ensure that there is sufficient time to complete the required actions by the 15th month.

With respect to the proposed amendment in §8.235(e), Atmos Energy had no comment on the proposed timing of the report, but does suggest that the Commission take this opportunity to clarify that the report is specific to transmission facilities within 1,000 feet of a public school building or recreational area. The Commission disagrees with this comment; no one has ever interpreted this rule as applying to distribution facilities.

With respect to the proposed amendments in §8.235(e) and §8.315(c), TPA pointed out in its comments on the initial proposal that many companies have both gas lines and hazardous liquids lines which often follow the same route. It is much more efficient for those companies to survey the routes of both types of lines at the same time instead of doing the gas line route one year and doing the same survey for the liquids lines in the same route the next year. Since submitting their initial comments, operators have further contemplated the best way to provide this information to the Commission without creating an undue burden on the operators or the Commission. TPA suggests that Commission require the information to be submitted to the Commission only once via an online system that can be updated by operators as changes occur. Operators would be required to update their list of schools as changes occur, but no less than one year from the date of the change. This solution will help streamline the reporting process in a manner that allows an active data base to be developed that remains updated. This simplifies the current reporting process that requires Commission staff to receive, sort, and enter information on a yearly basis, which is a very labor intensive process. TPA requests these changes be made to the appropriate sections of the

rule that would establish a reporting schedule outlined above. Further, a working group should be established to develop the system by which operators would report, change, and track their lists.

TxOGA believes that it would be a more efficient use of Commission and industry resources for this information to be furnished one time to allow creation of a Commission database, with pipeline operators then being required to update the information with a given time *(e.g.,* a year) of any change. TxOGA recommends that this be considered by the Commission in a future pipeline safety rulemaking.

The Commission disagrees with both comments. There is nothing in either §8.235(e) or §8.315(c), as proposed, that prohibits a company with both natural gas and hazardous liquids pipelines and/or facilities that follow the same route from filing the information every year. The even-numbered year filing deadline for operators of natural gas pipelines and/or facilities and the odd-numbered year filing deadline for operators of hazardous liquids pipelines and/or facilities is the longest that the interval between filing updated information may be. But if it is more efficient for those companies to survey the routes of both types of lines at the same time instead of doing the gas line route one year and doing the same survey for the liquids lines in the same route the next year, then the Commission has no objection to both reports being filed every year. In addition, updates to pipeline routes can be made online.

New amendments in §8.5 add a reference to 49 CFR Part 40, clarify the definitions of "master metered system" and "pressure test" in paragraphs (18) and (24), respectively, and add a reference to onshore pipeline, gathering, and production facilities to the definition of "transportation of gas" in paragraph (28). To address the concerns raised during the workshop regarding the definition of the gathering and regulated production facilities, the Commission adopts a revised definition of the term "transportation of gas" which includes a reference to the definition of "first point of measurement" that is found in 49 CFR Part 192.

The Commission adopts new wording in §8.115 to add a reference to Form PS-48 and to describe requirements for new construction reports.

The Commission adopts new §8.135 to move the penalty guidelines for pipeline safety violations from Subchapter C, which applies to requirements for natural gas pipelines only, to Subchapter B, so that the guidelines will apply to all pipelines. Most of the text of the rule is the same as §8.245, the repeal of which is adopted in a concurrent rulemaking, but Tables 1 and 5 have been amended to include references to the rules pertaining to hazardous liquids and carbon dioxide pipelines and pipeline facilities, and the Commission removed the provision in subsection (g) that prohibited reduction of a proposed penalty after a hearing has convened, in order to preserve flexibility in the administration of enforcement matters. These changes mean that penalty provisions for violations of the federal and Commission rules for all pipelines and specific provisions for operator qualification and integrity management for both natural gas and liquids pipelines are included in the rule.

In §8.203, the Commission adopts updated references to federal statutes that have been changed and with which operators already must comply.

The Commission adopts clarifying wording in §8.205 to state that supervisory review of leak complaints must be completed and documented by 10:00 a.m. of the next business day for calls received by midnight on the previous day.

In §8.210(a)(1), the Commission adopts amendments to add a reference to 49 CFR Part 191.3 and to delete some specific wording in subparagraphs (A) - (E) and paragraph (2) that is now covered by Part 191.3. In paragraph (3), renumbered to paragraph (2), the Commission adds new subparagraphs (F) and (G) to require including the telephone number of the operator's on-site person, and estimated property damage, including the cost of gas lost, to the operator, others, or both. In subparagraph (H) (currently designated as (F)), the Commission adopts new wording to state that ignition, explosion, rerouting of traffic, evacuation of any building, and media interest are considered significant facts that must be reported. In paragraph (3) (currently designated as (4)), the Commission adds a reference to 49 CFR Part 191 and new wording to describe Department of Transportation reports.

As adopted, §8.210(b)(1) includes the addition of the word "intrastate" for systems which must file pipeline safety annual reports, and the remainder of this paragraph is reworded to conform to the Department of Transportation reporting requirements. The Commission has added clarifying language permitting such reports to be filed with the Commission electronically, at the operator's election.

The Commission adopts new subsection (e) to require natural gas operators to submit on a semi-annual basis information regarding the number of repaired leaks on their pipeline facilities as well as the number of leaks remaining unrepaired. The Commission adopts this section with clarifying wording regarding the scope of the application, replacing "pipeline systems" with "pipeline facilities"; defining the term "leak"; and specifying that the requirements of this subsection are applicable to operators of gas distribution systems, regulated gas gathering lines, and plastic gas transmission lines.

Each operator is required to submit a listing of repaired leaks on proposed new Form PS-95 that describes the leak and the method of repair. The Form PS-95 report also requires reporting of information for the leaks on the system yet to be repaired, organized by leak grade. This new form incorporates the information required on the Plastic Pipe Failure Report, PS-80, and therefore the Commission also deletes §8.225(a), as discussed below. As proposed, the Form PS-95 reports were to be submitted electronically into the Commission's Pipeline Safety Integrity system on June 30 and December 31 of each calendar year. However, the Commission adopts a clarifying change to this section to move the deadlines for submitting the reports to later dates (July 15 and January 15) so that the reports will include data from January 1 through June 30 and from July 1 through December 31.

Step 1 on the online PS-95 Leak Report is to report the number of unrepaired leaks on the system by grade, as defined in §8.207(b) - (d). Step 2 is to report leaks that have been repaired. The Form PS-95 uses drop-down menus for many of the data elements required to be reported. For each leak repaired during the reporting period, the operator must provide the address; operator's leak identification number; date reported; whether above or below ground; the location on the pipe (*e.g.,* body of pipe, valve, joint, riser, tap, compression coupling, etc.); if on a joint, what type *(e.g.,* threaded, bell and spigot, flange, etc.); if on a fitting, what type *(e.g.,* saddle fitting, elbow, tee, split sleeve, meter swivel, etc.); if the type of fitting coupling was plastic or metal, the name of the manufacturer and the model; the facility type (main,

service, or transmission); the grade (1, 2, or 3); the pipe size; the type of pipe *(e.g.,* bare steel, coated steel, galvanized, copper, brass, PVC, etc.); the cause or causes of the leak (corrosion; excavation (operator personnel/contractors excavating, other third party excavators, locator, or vehicle); natural forces (lightning, washout, ground movement, ice, or static electricity); other outside forces (vandalism, fire/explosion, or excessive strain); materials and welds (dent, gouge, factory defect, wrinkle bend, weld (steel) or fusion defect (plastic)); equipment (equipment malfunction, gasket/o-ring, or packing); operations (inadequate/failure to follow procedures; stripped threads; or backfill), or other group (not excavated or other); the leak repair method *(e.g.,* clamp installed, split sleeve, replacement (component or pipe), greasing, doping/caulking, etc.); and the date of the repair.

The Commission is implementing two electronic filing methods for new Form PS-95 Leak Report, an online system and an Electronic Document Interchange (EDI) filing procedure. An organization *(i.e.,* a Form P-5 operator) must file a Security Administrator Designation (SAD) Form with the Commission as a requirement for filing online or using EDI. An account is created for the person designated on the SAD Form as the Security Administrator for the organization. This Security Administrator, in turn, can assign filing rights to the organization's employees that authorize them to file Commission forms electronically. Organizations that have existing SAD forms do not need to re-file; the existing Security Administrators will be able to assign Pipeline Integrity filing rights to the users within the RRC Online System.

Each file submitted to the Commission for EDI processing must have an Identifying Record as the first record in the file. The processing of this record includes the validation that the User ID is authorized to file electronically. An operator using spreadsheet software to compile data for the Form PS-95 will be able to export the file to a right curly bracket (}) delimited format for EDI submission. This application eliminates the requirement to submit a test file, but it will validate the format of each file submitted. Numeric columns must not contain any commas; *e.g.,* use 1000000 for one million, not 1,000,000. Nor should columns contain currency formatting like "$" or "USD." Data entry is case sensitive. A file not meeting the formatting requirements will be rejected. Filers will be required to correct the formatting error and resubmit the file. Since this check will be performed each time a file is submitted, the necessity of submitting and receiving a certification of formatting is redundant and therefore eliminated. However, the Commission will provide EDI filers with the capability to test files prior to submitting them to validate their EDI file formats. For specific records not meeting the filing requirements, the filer will receive error/approval feedback on the screen in the form of a message. A file may be resubmitted once all errors are corrected.

In §8.215, the Commission amends subsection (b) to require use of commercially available odorization equipment, and deletes references to shop-made equipment. The Commission also adopts additional clarifying wording regarding continued use of shop-made odorization equipment that has been previously approved by the Commission and is in service as of February 4, 2009, the effective date of these rules. In subsection (c), the Commission adopts amendments to require use of commercially available malodorants, and to change the reference in paragraph (3) from "1.0% or less by volume" to "one-fifth of the lower explosive limit." In subsection (d)(2), the Commission clarifies that malodorant tests must be done at intervals not exceeding 15 months, but at least once each calendar year; a similar change is proposed in subsection (e)(1) for malodorant concentration tests. Also, in paragraph (1), the Commission deletes subparagraph (A), retains the text of subparagraph (B) in paragraph (1), and redesignates items (i) - (iv) as subparagraphs (A) - (E).

With the addition of the new section for leak reporting, the Commission will combine the requirements of §8.225(1) into new §8.210(e); therefore, subsection (a) of §8.225 is deleted and the remaining subsections redesignated.

The Commission adopts clarifications in §8.230(c)(1) and (2); new paragraph (2)(A) states that school facility pipe testing includes all gas piping from the outlet of the purchase meter to each inlet valve of each appliance. Current subparagraphs (A) - (C) are redesignated as (B) - (D).

In §8.235(a), the Commission clarifies wording to state that liaison activities must be conducted at intervals not exceeding 15 months, but at least once each calendar year, and in subsection (e), to add a specific date of January 15 of each even-numbered year for certain information to be filed.

The Commission clarifies §8.301(a)(1)(A) with new items (vi), (vii), and (viii) that require an operator to include the telephone numbers of the operator and the operator's on-site person, and to specify that ignition, explosion, rerouting of traffic, evacuation of any building, and media interest are considered significant facts that must be reported. In subparagraph (B), the Commission adopts clarifying wording concerning submission to the Commission of copies of any reports submitted to the Department of Transportation. In paragraph (2)(A) and (B), the Commission adds the Commission's emergency telephone number and a clarifying statement regarding submission to the Commission of copies of Department of Transportation reports.

In subsection (b), the Commission adds that each operator must file an annual report for its intrastate systems located in Texas in the same manner as required by 49 CFR Part 195, using forms supplied by the Department of Transportation. The Commission has added clarifying language permitting such reports to be filed with the Commission electronically, at the operator's election, and has changed the filing deadline from March 15 to June 15 to match the deadline in the federal rules. The Commission adopts new subsection (c) requiring submission to the Commission of safety-related condition reports as specified in 49 CFR 195. Current subsection (c) is redesignated as subsection (d).

The Commission deletes from §8.305 the requirement in paragraph (1) for atmospheric corrosion control, redesignates the remaining paragraphs, and in redesignated paragraph (3) (currently paragraph (4)) changes the requirements for cathodic protection test stations. The Commission also deletes subparagraphs (A) and (B) from the monitoring and inspection requirement in current paragraph (5), renumbered as paragraph (4).

In §8.310(a), the Commission adds wording that liaison activities must be conducted at intervals not exceeding 15 months, but at least once each calendar year.

Finally, in §8.315(c), the Commission clarifies that pipeline owners and operators must file certain information on January 15 of each odd-numbered year.

SUBCHAPTER A. GENERAL REQUIREMENTS AND DEFINITIONS

16 TAC §8.5

The Commission adopts the amendments under Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all common carrier pipelines in Texas, persons owning or operating pipelines in Texas, and their pipelines and oil and gas wells, and authorize the Commission to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission as set forth in §81.051, including such rules as the Commission may consider necessary and appropriate to implement state responsibility under any federal law or rules governing such persons and their operations; Texas Natural Resources Code, §81.0531, which requires the Commission to adopt by rule guidelines to be used in determining the amount of the penalty for a violation of a provision of Title 3 of the Texas Natural Resources Code, or a rule, order, license, permit, or certificate that relates to pipeline safety; Texas Natural Resources Code, §§117.001 - 117.102, which give the Commission jurisdiction over all pipeline transportation of hazardous liquids or carbon dioxide and over all hazardous liquid or carbon dioxide pipeline facilities as provided by 49 United States Code Annotated, §§60101, *et seq.;* and Texas Utilities Code, §§121.201 - 121.210, which authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and to associated pipeline facilities within Texas to the maximum degree permissible under, and to take any other requisite action in accordance with, 49 United States Code Annotated, §§60101, *et seq.;* §121.251 and §121.252, which authorize the Commission to regulate the use of malodorants in natural gas; and §§121.5005 - 121.507, which give the Commission authority to regulate the testing of natural gas piping systems in school facilities.

Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251, 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.,* are affected by the amendments.

Statutory authority: Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251 and 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.*

Cross-reference to statute: Texas Natural Resources Code, Chapters 81 and Chapter 117; Texas Utilities Code, Chapter 121; and 49 United States Code Annotated, Chapter 601.

Issued in Austin, Texas, on January 15, 2009.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Mary Ross McDonald
Managing Director
Railroad Commission of Texas
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For further information, please call: (512) 475-1295

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SUBCHAPTER B. REQUIREMENTS FOR ALL PIPELINES

16 TAC §8.115, §8.135

The Commission adopts the amendments and new rule under Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all common carrier pipelines in Texas, persons owning or operating pipelines in Texas, and their pipelines and oil and gas wells, and authorize the Commission to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission as set forth in §81.051, including such rules as the Commission may consider necessary and appropriate to implement state responsibility under any federal law or rules governing such persons and their operations; Texas Natural Resources Code, §81.0531, which requires the Commission to adopt by rule guidelines to be used in determining the amount of the penalty for a violation of a provision of Title 3 of the Texas Natural Resources Code, or a rule, order, license, permit, or certificate that relates to pipeline safety; Texas Natural Resources Code, §§117.001 - 117.102, which give the Commission jurisdiction over all pipeline transportation of hazardous liquids or carbon dioxide and over all hazardous liquid or carbon dioxide pipeline facilities as provided by 49 United States Code Annotated, §§60101, *et seq.;* and Texas Utilities Code, §§121.201 - 121.210, which authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and to associated pipeline facilities within Texas to the maximum degree permissible under, and to take any other requisite action in accordance with, 49 United States Code Annotated, §§60101, *et seq.;* §121.251 and §121.252, which authorize the Commission to regulate the use of malodorants in natural gas; and §§121.5005 - 121.507, which give the Commission authority to regulate the testing of natural gas piping systems in school facilities.

Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251, 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.,* are affected by the amendments and new rule.

Statutory authority: Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251 and 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.*

Cross-reference to statute: Texas Natural Resources Code, Chapters 81 and Chapter 117; Texas Utilities Code, Chapter 121; and 49 United States Code Annotated, Chapter 601.

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§8.135. Penalty Guidelines for Pipeline Safety Violations.

(a) Only guidelines. This section complies with the requirements of Texas Natural Resources Code, §81.0531(d), and Texas Utilities Code, §121.206(d). The penalty amounts contained in the tables in this section are provided solely as guidelines to be considered by the Commission in determining the amount of administrative penalties for violations of provisions of Title 3 of the Texas Natural Resources Code relating to pipeline safety, or of rules, orders or permits relating to pipeline safety adopted under those provisions, and for violations of Texas Utilities Code, §121.201, or Subchapter I (§§121.451 - 121.454), or a safety standard or rule relating to the transportation of gas and gas pipeline facilities adopted under those provisions.

(b) Commission authority. The establishment of these penalty guidelines shall in no way limit the Commission's authority and discretion to assess administrative penalties in any amount up to the statutory maximum when warranted by the facts in any case.

(c) Factors considered. The amount of any penalty requested, recommended, or finally assessed in an enforcement action will be determined on an individual case-by-case basis for each violation, taking into consideration the following factors:

(1) the person's history of previous violations, including the number of previous violations;

(2) the seriousness of the violation and of any pollution resulting from the violation;

(3) any hazard to the health or safety of the public;

(4) the degree of culpability;

(5) the demonstrated good faith of the person charged; and

(6) any other factor the Commission considers relevant.

(d) Typical penalties. Typical penalties for violations of provisions of Title 3 of the Texas Natural Resources Code relating to pipeline safety, or of rules, orders, or permits relating to pipeline safety adopted under those provisions, and for violations of Texas Utilities Code, §121.201, or Subchapter I (§§121.451 - 121.454), or a safety standard or rule relating to the transportation of gas and gas pipeline facilities adopted under those provisions are set forth in Table 1.
Figure: 16 TAC §8.135(d)

(e) Penalty enhancements for certain violations. For violations that involve threatened or actual pollution; result in threatened or actual safety hazards; or result from the reckless or intentional conduct of the person charged, the Commission may assess an enhancement of the typical penalty, as shown in Table 2. The enhancement may be in any amount in the range shown for each type of violation.
Figure: 16 TAC §8.135(e)

(f) Penalty enhancements for certain violators. For violations in which the person charged has a history of prior violations within seven years of the current enforcement action, the Commission may assess an enhancement based on either the number of prior violations or the total amount of previous administrative penalties, but not both. The actual amount of any penalty enhancement will be determined on an individual case-by-case basis for each violation. The guidelines in Tables 3 and 4 are intended to be used separately. Either guideline may be used where applicable, but not both.
Figure 1: 16 TAC §8.135(f)
Figure 2: 16 TAC §8.135(f)

(g) Penalty reduction for settlement before hearing. The recommended penalty for a violation may be reduced by up to 50% if the person charged agrees to a settlement before the Commission conducts an administrative hearing to prosecute a violation. The reduction applies to the basic penalty amount requested and not to any requested enhancements.

(h) Demonstrated good faith. In determining the total amount of any penalty requested, recommended, or finally assessed in an enforcement action, the Commission may consider, on an individual case-by-case basis for each violation, the demonstrated good faith of the person charged. Demonstrated good faith includes, but is not limited to, actions taken by the person charged before the filing of an enforcement action to remedy, in whole or in part, a violation of the pipeline safety rules or to mitigate the consequences of a violation of the pipeline safety rules.

(i) Penalty calculation worksheet. The penalty calculation worksheet shown in Table 5 lists the typical penalty amounts for certain violations; the circumstances justifying enhancements of a penalty and the amount of the enhancement; and the circumstances justifying a reduction in a penalty and the amount of the reduction.
Figure: 16 TAC §8.135(i)

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. REQUIREMENTS FOR NATURAL GAS PIPELINES ONLY

16 TAC §§8.203, 8.205, 8.210, 8.215, 8.225, 8.230, 8.235

The Commission adopts the amendments under Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all common carrier pipelines in Texas, persons owning or operating pipelines in Texas, and their pipelines and oil and gas wells, and authorize the Commission to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission as set forth in §81.051, including such rules as the Commission may consider necessary and appropriate to implement state responsibility under any federal law or rules governing such persons and their operations; Texas Natural Resources Code, §81.0531, which requires the Commission to adopt by rule guidelines to be used in determining the amount of the penalty for a violation of a provision of Title 3 of the Texas Natural Resources Code, or a rule, order, license, permit, or certificate that relates to pipeline safety; Texas Natural Resources Code, §§117.001 - 117.102, which give the Commission jurisdiction over all pipeline transportation of hazardous liquids or carbon dioxide and over all hazardous liquid or carbon dioxide pipeline facilities as provided by 49 United States Code Annotated, §§60101, *et seq.;* and Texas Utilities Code, §§121.201 - 121.210, which authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and to associated pipeline facilities within Texas to the maximum degree permissible under, and to take any other requisite action in accordance with, 49 United States Code Annotated, §§60101, *et seq.;* §121.251 and §121.252, which authorize the Commission to regulate the use of malodorants in natural gas; and §§121.5005 - 121.507, which give the Commission authority to regulate the testing of natural gas piping systems in school facilities.

Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251, 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.,* are affected by the amendments.

Statutory authority: Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251 and 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.*

Cross-reference to statute: Texas Natural Resources Code, Chapters 81 and Chapter 117; Texas Utilities Code, Chapter 121; and 49 United States Code Annotated, Chapter 601.

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§8.205. Written Procedure for Handling Natural Gas Leak Complaints.

Each gas company shall have written procedures which shall include at a minimum the following provisions:

(1) a procedure or method for receiving leak complaints or reports, or both, on a 24-hour, seven day per week basis;

(2) a requirement to make and maintain a written record of all calls received and actions taken;

(3) a requirement that supervisory review of leak complaints must be completed and documented by 10:00 a.m. of the next business day for calls received by midnight on the previous day;

(4) standards for training and equipping personnel used in the investigation of leak complaints or reports, or both;

(5) procedures for locating the source of a leak and determining the degree of hazard involved;

(6) a chain of command for service personnel to follow if assistance is required in determining the degree of hazard;

(7) instructions to be issued by service personnel to customers or the public or both, as necessary, after a leak is located and the degree of hazard determined.

§8.210. Reports.

(a) Accident, leak, or incident report.

(1) Telephonic report. At the earliest practical moment or within two hours following discovery, a gas company shall notify the Commission by telephone of any event that involves a release of gas from its pipelines defined as an incident in 49 CFR Part 191.3.

(2) The telephonic report shall be made to the Commission's 24-hour emergency line at (512) 463-6788 and shall include the following:

(A) the operator or gas company's name;

(B) the location of the leak or incident;

(C) the time of the incident or accident;

(D) the fatalities and/or personal injuries;

(E) the phone number of the operator;

(F) the telephone number of the operator's on-site person;

(G) estimated property damage, including the cost of gas lost, to the operator, others, or both; and

(H) any other significant facts relevant to the accident or incident. Ignition, explosion, rerouting of traffic, evacuation of any building, and media interest are included as significant facts.

(3) Written report.

(A) Following the initial telephonic report for accidents, leaks, or incidents described in paragraph (1) of this subsection, the operator who made the telephonic report shall submit to the Commission a written report summarizing the accident or incident. The report shall be submitted as soon as practicable within 30 calendar days after the date of the telephonic report. The written report shall be made on forms supplied by the Department of Transportation. For reports submitted electronically to the Department of Transportation, the operator shall forward a copy of the report and confirmation to the Division or electronically to safety@rrc.state.tx.us. For reports not submitted electronically to the Department of Transportation, the operator shall send to the Division an original signed report form.

(B) The written report is not required to be submitted for master metered systems.

(C) The Commission may require an operator to submit a written report for an accident or incident not otherwise required to be reported.

(b) Pipeline safety annual reports.

(1) Except as provided in paragraph (2) of this subsection, each gas company shall submit an annual report for its intrastate systems in the same manner as required by 49 CFR Part 191. The report shall be submitted to the Division on forms supplied by the Department of Transportation not later than March 15 of a year for the preceding calendar year. For reports submitted electronically to the Department of Transportation, the operator may forward a copy of the report and confirmation to the Division or electronically to safety@rrc.state.tx.us. For reports not submitted electronically to the Department of Transportation, the operator shall send to the Division an original signed report form.

(2) The annual report is not required to be submitted for:

(A) a petroleum gas system, as that term is defined in 49 CFR 192.11, which serves fewer than 100 customers from a single source; or

(B) a master metered system.

(c) Safety related condition reports. Each gas company shall submit to the Division in writing a safety-related condition report for any condition outlined in 49 CFR 191.23.

(d) Offshore pipeline condition report. Within 60 days of completion of underwater inspection, each operator shall file with the Division a report of the condition of all underwater pipelines subject to 49 CFR 192.612(a). The report shall include the information required in 49 CFR 191.27.

(e) Leak Reporting. For purposes of this subsection, the term "leak" includes all underground leaks, all hazardous above ground leaks, and all non-hazardous above ground leaks that cannot be eliminated by lubrication, adjustment, or tightening. Each operator of a gas distribution system, of a regulated plastic gas gathering line, or of a plastic gas transmission line shall submit to the Division a list of all leaks repaired on its pipeline facilities. Each such operator shall list all leaks identified on all pipeline facilities. Each such operator shall also include the number of unrepaired leaks remaining on the operator's systems by leak grade. Each such operator shall submit leak reports using the Commission's online reporting system, Form PS-95, by July 15 and January 15 of each calendar year, in accordance with the PS-95 Semi-Annual Leak Report Electronic Filing Requirements, set out in the Figure in this subsection. The report submitted on July 15 shall include information from the previous January 1 through the previous June 30. The report submitted on January 15 shall include information from the previous July 1 through the previous December 31. The report includes:

(1) leak location;

(2) facility type;

(3) leak classification;

(4) pipe size;

(5) pipe type;

(6) leak cause; and

(7) leak repair method.

Figure: 16 TAC §8.210(e)(7)

§8.215. Odorization of Gas.

(a) Odorization of gas.

(1) Each gas company shall continuously odorize gas by the use of a malodorant agent as set forth in this section unless the gas contains a natural malodor or is odorized prior to delivery by a supplier.

(2) Unless required by 49 CFR Part 192.625(B) or by this section, odorization is not required for:

(A) gas in underground or other storage;

(B) gas used or sold primarily for use in natural gasoline extraction plants, recycling plants, chemical plants, carbon black plants, industrial plants, or irrigation pumps; or

(C) gas used in lease and field operation or development or in repressuring wells.

(3) Gas shall be odorized by the user if:

(A) the gas is delivered for use primarily in one of the activities or facilities listed in paragraph (2) of this subsection and is also used in one of those activities for space heating, refrigeration, water heating, cooking, and other domestic uses; or

(B) the gas is used for furnishing heat or air conditioning for office or living quarters.

(4) In the case of lease users, the supplier shall ensure that the gas will be odorized before being used by the consumer.

(b) Odorization equipment. Gas companies shall use commercially available odorization equipment in any installation made on or after February 4, 2009. Shop-made or other odorization equipment previously approved by the Commission and in use as of February 4, 2009, may continue to be used in its current service, but may not be re-installed in a different location. Each operator shall be required to maintain a list of odorization equipment used in its particular operations, including the location of the odorization equipment, the brand name, model number, and the date last serviced. The list shall be available for review during safety evaluations by the Division.

(c) Malodorants. Gas companies shall use commercially available malodorants which shall meet the following criteria.

(1) The malodorant when blended with gas in the amount specified for adequate odorization of the gas shall not be deleterious to humans or to the materials present in a gas system and shall not be soluble in water to a greater extent than 2 1/2 parts by weight of malodorant to 100 parts by weight of water.

(2) The products of combustion from the malodorant shall be nontoxic to humans breathing air containing the products of combustion and the products of combustion shall not be corrosive or harmful to the materials to which such products of combustion would ordinarily come in contact.

(3) The malodorant agent to be introduced in the gas, or the natural malodor of the gas, or the combination of the malodorant and the natural malodor of the gas shall have a distinctive malodor so that when gas is present in air at a concentration of one-fifth of the lower explosive limit, the malodor is readily detectable by an individual with a normal sense of smell.

(4) The level of natural malodor or the injection rate of approved malodorant shall be sufficient to achieve the requirement of paragraph (3) of this subsection.

(d) Malodorant tests and reports.

(1) Malodorant injection report. Each gas company shall record as frequently as necessary to maintain adequate odorization but not less than once each quarter the following malodorant information for all odorization equipment, except farm tap odorizers. The required information shall be recorded and retained in the company's files:

(A) odorizer location;

(B) brand name and model of odorizer;

(C) name of malodorant, concentrate, or dilute;

(D) quantity of malodorant at beginning of month/quarter;

(E) amount added during month/quarter;

(F) quantity at end of month/quarter;

(G) MMcf of gas odorized during month/quarter; and

(H) injection rate per MMcf.

(2) Each natural gas operator shall check, test, and service farm tap odorizers at intervals not exceeding 15 months, but at least once each calendar year. Each gas company shall maintain records to reflect the date of service and maintenance on file for at least two years.

(e) Malodorant concentration tests and reports.

(1) Each gas company shall conduct the following concentration tests on the gas supplied through its facilities and required to be odorized. Test points shall be distant from odorizing equipment, so as to be representative of the odorized gas in the system. Tests shall be performed at intervals not exceeding 15 months, but at least once each calendar year or at such other times as the Division may reasonably require. The results of these tests shall be recorded and retained in each company's files for at least two years. Malodorant concentration test results shall include the following:

(A) odorizer name and location;

(B) malodorant concentration meter make, model, and serial number;

(C) date test performed, test time, odorizer tested, and distance from odorizer;

(D) test results indicating percent gas in air when malodor is readily detectable; and

(E) signature of person performing the test.

(2) Farm tap odorizers shall be exempt from the odorization testing requirements of paragraph (1) of this subsection.

(3) Gas companies that obtain gas into which malodorant previously has been injected or gas which is considered to have a natural malodor and therefore do not odorize the gas themselves shall be required to conduct quarterly malodorant concentration tests and retain records for a period of two years.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. REQUIREMENTS FOR HAZARDOUS LIQUIDS AND CARBON DIOXIDE PIPELINES ONLY

16 TAC §§8.301, 8.305, 8.310, 8.315

The Commission adopts the amendments under Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all common carrier pipelines in Texas, persons owning or operating pipelines in Texas, and their pipelines and oil and gas wells, and authorize the Commission to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission as set forth in §81.051, including such rules as the Commission may consider necessary and appropriate to implement state responsibility under any federal law or rules governing such persons and their operations; Texas Natural Resources Code, §81.0531, which requires the Commission to adopt by rule guidelines to be used in determining the amount of the penalty for a violation of a provision of Title 3 of the Texas Natural Resources Code, or a rule, order, license, permit, or certificate that relates to pipeline safety; Texas Natural Resources Code, §§117.001 - 117.102, which give the Commission jurisdiction over all pipeline transportation of hazardous liquids or carbon dioxide and over all hazardous liquid or carbon dioxide pipeline facilities as provided by 49 United States Code Annotated, §§60101, *et seq.;* and Texas Utilities Code, §§121.201 - 121.210, which authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and to associated pipeline facilities within Texas to the maximum degree permissible under, and to take any other requisite action in accordance with, 49 United States Code Annotated, §§60101, *et seq.;* §121.251 and §121.252, which authorize the Commission to regulate the use of malodorants in natural gas; and §§121.5005 - 121.507, which give the Commission authority to regulate the testing of natural gas piping systems in school facilities.

Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251, 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.,* are affected by the amendments.

Statutory authority: Texas Natural Resources Code, §§81.051, 81.052, 81.0531, and 117.001 - 117.102; Texas Utilities Code, §§121.201 - 121.211; 121.251 and 121.252; and 121.5005 - 121.507; and 49 United States Code Annotated, §§60101, *et seq.*

Cross-reference to statute: Texas Natural Resources Code, Chapters 81 and Chapter 117; Texas Utilities Code, Chapter 121; and 49 United States Code Annotated, Chapter 601.

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§8.301. Required Records and Reporting.

(a) Accident reports. In the event of any failure or accident involving an intrastate pipeline facility from which any hazardous liquid or carbon dioxide is released, if the failure or accident is required to be reported by 49 CFR Part 195, the operator shall report to the Commission as follows.

(1) Incidents involving crude oil. In the event of an accident involving crude oil, the operator shall:

(A) notify the Division, which shall notify the Commission's appropriate Oil and Gas district office, by telephone to the Commission's emergency line at (512) 463-6788 at the earliest practicable moment following discovery of the incident (within two hours) and include the following information:

(i) company/operator name;

(ii) location of leak or incident;

(iii) time and date of accident/incident;

(iv) fatalities and/or personal injuries;

(v) phone number of operator;

(vi) telephone number of operator;

(vii) telephone number of the operator's on-site person;

(viii) other significant facts relevant to the accident or incident. Ignition, explosion, rerouting of traffic, evacuation of any building, and media interest are included as significant facts.

(B) within 30 days of discovery of the incident, submit a completed Form H-8 to the Oil and Gas Division of the Commission. In situations specified in the 49 CFR Part 195, the operator shall also file a copy of the required Department of Transportation form with the Division. For reports submitted electronically to the Department of Transportation, the operator shall forward a copy of the report and confirmation to the Division or electronically to safety@rrc.state.tx.us. If an operator does not submit reports electronically to the Department of Transportation, the operator shall send the report to the Division on an original signed report form.

(2) Hazardous liquids, other than crude oil, and carbon dioxide. For incidents involving hazardous liquids, other than crude oil, and carbon dioxide, the operator shall:

(A) notify the Division of such incident by telephone to the Commission's emergency line at (512) 463-6788 at the earliest practicable moment following discovery (within two hours) and include the information listed in paragraph (1)(A)(i) - (viii) of this subsection; and

(B) within 30 days of discovery of the incident, file with the Division a written report using the appropriate Department of Transportation form (as required by 49 CFR Part 195) or a facsimile. For reports submitted electronically to the Department of Transportation, the operator shall forward a copy of the report and confirmation to the Division or electronically to safety@rrc.state.tx.us. If an operator does not submit reports electronically to the Department of Transportation, the operator shall send the report to the Division on an original signed report form.

(b) Annual report. Each operator shall file with the Commission an annual report for its intrastate systems located in Texas in the same manner as required by 49 CFR Part 195. The report shall be filed with the Commission on forms supplied by the Department of Trans-

portation on or before June 15 of a year for the preceding calendar year reported. For reports submitted electronically to the Department of Transportation, the operator may forward a copy of the report and confirmation to the Division or electronically to safety@rrc.state.tx.us. For reports not submitted electronically to the Department of Transportation, the operator shall send to the Division an original signed report form.

(c) Safety-related condition reports. Each operator shall submit to the Division in writing a safety-related condition report for any condition specified in 49 CFR 195.

(d) Facility response plans. Simultaneously with filing either an initial or a revised facility response plan with the United States Department of Transportation, each operator shall submit to the Division a copy of the initial or revised facility response plan prepared under the Oil Pollution Act of 1990, for all or any part of a hazardous liquid pipeline facility located landward of the coast.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900211
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: February 4, 2009
Proposal publication date: October 10, 2008
For further information, please call: (512) 475-1295

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SUBCHAPTER C. REQUIREMENTS FOR NATURAL GAS PIPELINES ONLY

16 TAC §8.245

The Railroad Commission of Texas adopts the repeal of §8.245, relating to Penalty Guidelines for Pipeline Safety Violations, without changes to the proposal published in the October 10, 2008, issue of the *Texas Register* (33 TexReg 8475). The Commission adopts the repeal in order to adopt the same rule under a different rule number. The new §8.135, with the same title, is adopted in a concurrent rulemaking. The effective date of the repeal will be February 4, 2009.

The Commission received no comments on the proposed repeal.

The Commission adopts the repeal under Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all common carrier pipelines in Texas, persons owning or operating pipelines in Texas, and their pipelines and oil and gas wells, and authorize the Commission to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission as set forth in §81.051, including such rules as the Commission may consider necessary and appropriate to implement state responsibility under any federal law or rules governing such persons and their operations; Texas Natural Resources Code, §81.0531, which requires the Commission to adopt by rule guidelines to be used in determining the amount of the penalty for a violation of a provision of Title 3 of the Texas Natural Resources Code, or a rule, order, license, permit, or certificate that relates to pipeline safety; and Texas Utilities Code, §§121.201-121.210, which authorize the Commission to adopt safety standards and practices applicable to the transportation of gas and to associated pipeline facilities within Texas to the maximum degree permissible under, and to take any other requisite action in accordance with, 49 United States Code Annotated, §§60101, *et seq*.

Texas Natural Resources Code, §§81.051, 81.052, and 81.0531; Texas Utilities Code, §§121.201-121.210; and 49 United States Code Annotated, §§60101, *et seq.*, are affected by the repeal.

Statutory authority: Texas Natural Resources Code, §§81.051, 81.052, and 81.0531; Texas Utilities Code, §§121.201-121.210; and 49 United States Code Annotated, §§60101, *et seq.*

Cross-reference to statute: Texas Natural Resources Code, §§81.051, 81.052, and 81.0531; Texas Utilities Code, Chapter 121; and 49 United States Code Annotated, Chapter 601.

Issued in Austin, Texas, on January 15, 2009.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Mary Ross McDonald
Managing Director
Railroad Commission of Texas
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For further information, please call: (512) 475-1295

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PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 47. BLANKET RULES

16 TAC §47.1, §47.2

The Texas Alcoholic Beverage Commission adopts the repeal of Chapter 47, titled Blanket Rules, which includes §47.1, relating to severability, and §47.2, relating to blanket penalty, without changes to the proposed text as published in the October 10, 2008, issue of the *Texas Register* (33 TexReg 8476).

Government Code, §2001.39 requires that each state agency review and consider for readoption every four years each rule adopted by the agency under Government Code, Chapter 2001. Section 47.1 and §47.2 have been reviewed and the commission has determined that they are obsolete and are no longer necessary. The adoption of the Administrative Procedure Act, Government Code, Chapter 2001, has made §47.1 obsolete. Sections 11.61 - 11.65 and 61.71 - 61.79 of the Alcoholic Beverage Code, and Chapter 34 of the agency rules have made §47.2 obsolete. Additionally, there is no necessity after the repeal of these sections to have a chapter entitled Blanket Rules.

No comments were received as a result of the proposed repeal of the chapter.

Repeal of the existing rules is authorized by §5.31 of the Alcoholic Beverage Code, which provides the Texas Alcoholic Bever-

age Commission with the authority to prescribe and publish rules necessary to carry out the provisions of the Alcoholic Beverage Code, and §2001.039 of the Government Code.

Cross Reference: Section 5.31 is affected by the repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900185
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Effective date: February 3, 2009
Proposal publication date: October 10, 2008
For further information, please call: (512) 206-3204

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CHAPTER 49. PRODUCTION OF ALCOHOLIC BEVERAGES

16 TAC §49.1

The Texas Alcoholic Beverage Commission adopts the repeal of Chapter 49, titled Production of Alcoholic Beverages, which includes §49.1, relating to production practices in general, without changes to the proposed text as published in the October 10, 2008, issue of the *Texas Register* (33 TexReg 8476).

Government Code, §2001.39 requires that each state agency review and consider for readoption every four years each rule adopted by the agency under Government Code, Chapter 2001.

Section 49.1 relates to good manufacturing standards for wineries, wine bottlers and rectifiers. The section was adopted in 1976 and it has not been updated for current good manufacturing standards. Further, the Department of State Health Services (DSHS) regulates, inspects, and adopts rules for good manufacturing standards for all food manufacturers, which include wineries, wine bottlers and rectifiers. DSHS inspectors have expertise and special training in good manufacturing standards while our agents and auditors are not trained in this area and do not perform inspections to ensure compliance with this rule. This rule is no longer necessary as a commission rule. Additionally, there is no necessity after the repeal of this section to have a chapter entitled Production of Alcoholic Beverages.

No comments were received as a result of the proposed repeal of Chapter 49.

The repeal of the existing rule is authorized by §5.31 of the Alcoholic Beverage Code, which provides the Texas Alcoholic Beverage Commission with the authority to prescribe and publish rules necessary to carry out the provisions of the Alcoholic Beverage Code, and §2001.039 of the Government Code.

Cross Reference: Section 5.31 is affected by the repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 14, 2009.

TRD-200900186
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Effective date: February 3, 2009
Proposal publication date: October 10, 2008
For further information, please call: (512) 206-3204

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TITLE 22. EXAMINING BOARDS

PART 17. TEXAS STATE BOARD OF PLUMBING EXAMINERS

CHAPTER 365. LICENSING AND REGISTRATION

22 TAC §365.5

The Texas State Board of Plumbing Examiners (Board) adopts amendments to §365.5, concerning Renewals. The Board adopts the rule amendments, without changes to the proposed text as published in the October 31, 2008, issue of the *Texas Register* (33 TexReg 8877). Prior to proposal of the rule amendments, two public meetings were conducted in order to develop the needed amendments. The Board's Continuing Professional Education (CPE) Committee conducted a public meeting on September 8, 2008, and considered public and staff comments regarding the development of the rule amendments. The full Board considered the comments of the public, staff and the CPE Committee at a public meeting on October 13, 2008 prior to proposing the rule. The Board authorized the proposal of the amendments on October 13, 2008.

The amendments to §365.5, which set forth registration, license and endorsement renewal requirements, are adopted to clarify Board policy which provides alternate methods for certain individuals to receive credit for Continuing Professional Education (CPE) required for the renewal of a license issued by the Board. The individuals who are the subject of the rule amendments typically receive much more than the minimum 6 hours of CPE required by the Plumbing License Law and Board Rules, during the course of the individuals' regular duties. The individuals are CPE Course Instructors who are fully approved by the Board to teach CPE, Board employees who monitor CPE classes for compliance with the Plumbing License Law, and Board employees who review all Course Materials during the Board's approval process and complete the Board's Course Instructor Certification Workshop annually.

No comments were received regarding the proposed rule amendment since the proposed text was published in the *Texas Register.*

The amendments to §365.5 are adopted under and affect Title 8, Chapter 1301, Occupations Code, as amended by the 78th Legislature ("Plumbing License Law" or "Law"), §1301.251, §1301.404, and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.404 requires the Board to adopt criteria and administer CPE programs and allows the Board to exempt certain persons from the requirements of that

section, if the Board determines the exemption is in the public interest. The amendments to §365.5 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, HB 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if a proposed rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these rule amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2009.

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Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
Effective date: February 2, 2009
Proposal publication date: October 31, 2008
For further information, please call: (512) 936-5224

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22 TAC §365.14

The Texas State Board of Plumbing Examiners (Board) adopts amendments to §365.14, concerning Continuing Professional Education Programs. The Board adopts the rule amendments, without changes to the proposed text as published in the October 31, 2008, issue of the *Texas Register* (33 TexReg 8878). Prior to proposal of the rule amendments, two public meetings were conducted in order to develop the needed amendments. The Board's Continuing Professional Education (CPE) Committee conducted a public meeting on September 8, 2008, and considered public and staff comments regarding the development of the rule amendments. The full Board considered the comments of the public, staff and the CPE Committee at a public meeting on October 13, 2008 prior to proposing the rule. The Board authorized the proposal of the amendments on October 13, 2008.

Section 365.14 sets forth the criteria adopted by the Board for continuing professional education (CPE) programs for the renewal of licenses issued by the Board. The amendments to §365.14 are adopted in order to delete obsolete language, update procedures to current practices and implement new procedures to ensure that the programs continue to provide quality continuing professional education to the licensees. The amendments will result in better protection of the health and safety of the public through better education of the plumbing industry.

The following subsections are amended:

Section 365.14(a) deletes obsolete language and clarifies the intent of Course Materials to be used as reference material.

Section 365.14(a)(4) replaces obsolete reference to Vernon's Civil Statutes.

Section 365.14(a)(6) allows draft versions of Course Materials to be submitted to the Board in a draft form.

Section 365.14(a)(7) eliminates reference to evaluation forms no longer required under current practice.

Section 365.14(a)(12)(C) requires Course Material applicants to report felony convictions.

Section 365.14(a)(12)(D) clarifies current requirement for Course Material applicants to submit certificate of good standing from Texas Comptroller of Public Accounts.

Section 365.14(a)(12)(G) requires contact information for Course Material applicants.

Section 365.14(a)(13) clarifies language which requires a Course Material Provider to sell Course Materials at the same price, regardless to whom the Course Material Provider chooses to sell Course Materials.

Section 365.14(a)(14) eliminates reference to evaluation forms no longer required under current practice.

Section 365.14(a)(16) clarifies the approval period of Course Materials and adds flexibility for periods of use.

Section 365.14(a)(17)(A) clarifies that Course Materials must accompany Course Material Provider applications when submitted to the Board for approval.

Section 365.14(b)(5) provides an exception to CPE class size limitations to military personnel on active duty.

Section 365.14(b)(7) clarifies requirements for CPE Certificates of Completion and eliminates obsolete language.

Section 365.14(b)(10) clarifies CPE class notification requirements, allows Course Providers to notify the Board of scheduled CPE classes via the Course Provider's website, and prescribes procedures to help avoid cancellation of CPE classes by Course Providers, including procedures for rescheduling classes when necessary.

Section 365.14(b)(11) clarifies the intent of required self monitoring of CPE classes by the Course Providers.

Section 365.14(b)(12) eliminates outdated language regarding the Course Instructor application process and clarifies current requirements.

Section 365.14(b)(15)(C) requires Course Provider applicants to self report felony convictions.

Section 365.14(b)(15)(D) clarifies current requirement for Course Provider applicants to submit certificate of good standing from Texas Comptroller of Public Accounts.

Section 365.14(b)(15)(F) requires Course Providers to include their electronic mail address in the application.

Section 365.14(b)(15)(K) revises content requirements for Course Provider reports submitted to the Board.

Section 365.14(b)(15)(N) requires Course Providers to designate a primary contact person who will communicate with the Board.

Section 365.14(b)(16)(C) eliminates unnecessary reference to Course Provider evaluation forms. Unsatisfactory evaluations of Course Providers and Course Instructors are more effectively handled through the Board's complaint processes.

Section 365.14(b)(18) clarifies approval period of Course Providers.

Section 365.14(b)(19) deletes obsolete language regarding submittal of Course Provider applications.

Section 365.14(c) clarifies current requirements that Course Instructor applications must be submitted by a Course Provider.

Section 365.14(c)(4)(A) clarifies that Course Instructors must ensure that their classroom CPE presentations must be based only on Board approved Course Materials and other materials approved by the Board.

Section 365.14(c)(4)(D) requires the Course Instructor to notify the Course Provider immediately, if the Course Instructor is unable to provide instruction for a CPE class that the instructor was scheduled to instruct, to allow the Course Provider to make every effort to provide a substitute Course Instructor to avoid cancelling the class.

Section 365.14(c)(7) Requires the Course Instructor to, at the beginning of each CPE class, provide each individual student with a separate single page handout containing the text of §365.14(c)(4) - (6), in a format provided by the Board. This will ensure that each student receives notice of what is required of the instructor and the student during the CPE class.

No comments were received regarding the proposed rule amendment since the proposed text was published in the *Texas Register.*

The amendments to §365.14 are adopted under and affect Title 8, Chapter 1301, Occupations Code, as amended by the 78th Legislature ("Plumbing License Law" or "Law"), §1301.251, Subchapter I, Board rules Chapter 367 and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Subchapter I sets forth the Board's disciplinary procedures. Chapter 367 of the Board rules sets forth the Board's enforcement procedures, grounds for disciplinary actions and standards of conduct for licensees. The amendments to §365.14 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, HB 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if a proposed rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by this adopted amendment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2009.

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Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
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Proposal publication date: October 31, 2008
For further information, please call: (512) 936-5224

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CHAPTER 367. ENFORCEMENT

22 TAC §367.1

The Texas State Board of Plumbing Examiners adopts amendments to §367.1, concerning General Provisions, without changes to the proposed text as published in the October 31, 2008, issue of the *Texas Register* (33 TexReg 8883).

Currently, the Board has adopted the Uniform Plumbing Code (UPC), as published by the International Association of Plumbing and Mechanical Officials (IAPMO) and the International Plumbing Code (IPC), as published by the International Code Council (ICC). As specified by §1301.255(a) of the Plumbing License Law (Title 8, Chapter 1301, Occupations Code), the Board has adopted the two codes as they existed on May 31, 2001, which are the 2000 editions of both codes. Section 1301.255(b) of the Plumbing License Law authorizes the Board to adopt later editions of the two codes.

Each edition of the plumbing codes is continually reviewed by a wide diversity of industry experts. The result is a new edition of the codes being published approximately every three years, ensuring that proper installation of plumbing systems will better protect public health and safety.

Section 1301.255 of the Plumbing License Law specifically names the UPC and the IPC as the two codes to be adopted by the Board. The UPC contains all of the requirements for installation of plumbing within the one code. However, the IPC requires fuel gas plumbing to be installed according to the requirements of the International Fuel Gas Code and residential plumbing to be installed in accordance with the International Residential Code. Additionally, Chapter 214, Subchapter G of the Local Government Code, requires municipalities to adopt the International Residential Code. For those reasons, the language in the proposed amendment includes the International Fuel Gas Code and the International Residential Codes, the two codes referenced within the International Plumbing Code. Including the names of the two codes referenced within the IPC will provide clarity to the public, plumbing industry, municipalities, and owners of public water systems.

The rule amendments will require individuals who are preparing for examinations administered by the Board to prepare for the examinations using the 2006 Uniform Plumbing Code or the 2006 International Plumbing Code. Applicants for examination who choose the 2006 International Plumbing Code to prepare would also study the 2006 International Fuel Gas Code and the 2006 International Residential Code, as applicable. Applicants who choose the 2006 Uniform Plumbing Code would also study the 2006 International Residential Code, as applicable. The portions of the examinations which cover liquefied petroleum gas (LPG) systems, are based on the codes adopted by the Texas Railroad Commission (RRC), which regulates the installation of LPG systems in Texas.

The amendments require plumbing to be installed in accordance with the plumbing codes applicable to the area or jurisdiction where the plumbing is installed. Plumbing installed within local jurisdictions which have adopted a plumbing code will continue to be installed in accordance with the code adopted by the local jurisdiction.

The rule amendments will also require licensed plumbers who install plumbing in geographical areas where no plumbing code has been adopted and not otherwise subject to regulation under the Plumbing License Law or another state law, to install plumbing in accordance with a 2006 edition of a plumbing code adopted by the Board.

Incomplete plumbing installations which commenced under the requirements of an earlier edition of the plumbing codes and prior to the Board's adoption of the 2006 editions of the plumb-

ing codes, may continue to completion under the requirements of the earlier edition.

All LPG systems must be installed in accordance with the rules of the RRC. Many licensed plumbers in Texas are also licensed by the RRC to install LPG systems and, therefore, should be knowledgeable of the codes adopted by RRC.

The rule amendments also update an obsolete reference in §367.1(b), which refers to disciplinary procedures which were previously found in Chapter 365. The amendments correctly state that the procedures are now found in Chapter 367 of the rules.

The amendments also update language in §367.1(h), which establish no new requirements, but reflect changes made to §1301.255(e) of the Plumbing License Law by the 80th Legislature.

No comments were received regarding the proposed rule amendment since the proposed text was published in the *Texas Register.*

The amendments to §367.1 are adopted under and affect Title 8, Chapter 1301, Occupations Code ("Plumbing License Law"), §1301.251, §1301.255, and the rule it amends. Section 1301.251 requires the Board to adopt and enforce rules necessary to administer the Plumbing License Law. Section 1301.255 allows the Board to adopt later editions of plumbing codes and requires plumbing installed by licensed plumbers in geographical areas where no local jurisdiction has adopted a plumbing code, to be installed in accordance with the codes adopted by the Board. The amendments to §367.1 are also adopted under Texas Government Code §2006.002, as amended by the 80th Legislature, HB 3430, which requires an agency to perform an Economic Impact Statement and Regulatory Flexibility Analysis if a proposed rule could have an adverse economic impact on small businesses.

No other statute, article or code is affected by these rule amendments.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Robert L. Maxwell
Executive Director
Texas State Board of Plumbing Examiners
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For further information, please call: (512) 936-5224

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE, NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES AND ANNUITY CONTRACTS, AND LIFE INSURANCE POLICIES THAT PROVIDE LONG-TERM CARE BENEFITS WITHIN THE POLICY

The Commissioner of Insurance adopts amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, and 3.3846, and new §§3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874, concerning standards for long-term care non-partnership insurance coverage, long-term care partnership insurance coverage under individual and group policies, annuity contracts, and life insurance policies that provide long-term care benefits within the policy or by rider. Sections 3.3803, 3.3804, 3.3826, 3.3829, 3.3830, 3.3837, 3.3839, 3.3842, 3.3844, 3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874 are adopted with changes to the proposed text published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635). Sections 3.3801, 3.3802, 3.3821, 3.3833, 3.3834, 3.3838, and 3.3846, are adopted without changes. A correction of error was published in the *Texas Register* on August 8, 2008 (33 TexReg 6446) to correct an error in the July 18 publication of the proposal of §3.3842(j). As published in the July 18 issue, the last sentence of §3.3842(j) reads: "If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter requirements and procedures apply:". As corrected, the last sentence of subsection (j) reads: "If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter *and the* requirements and procedures *that* apply:".

The adoption of the proposed amendments and the proposed new sections were considered by the Commissioner in a public hearing held under Docket Number 2689, at 9:30 a.m. on August 12, 2008, in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

REASONED JUSTIFICATION. The adopted amendments and new sections are necessary to implement the insurance related provisions of Senate Bill (SB) 22, as enacted by the 80th Legislature, Regular Session, effective March 1, 2008. SB 22 establishes a state partnership for long-term care program in Texas that is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. In enacting SB 22, the Legislature found that long-term care is currently one of the leading cost drivers in the Medicaid program. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Enrolled), SB 22, 80th Legislature, Regular Session (October 18, 2007)). Further legislative findings indicate several other relevant factors. Although Medicaid pays for 67 percent of all nursing facility days in Texas, less than five percent of Texans have private long-term care insurance. As the population in Texas ages, the fiscal impact of publicly financ-

ing long-term care may lessen if more Texans purchase private long-term care insurance. However, prior to the enactment of SB 22, the law did not provide any incentive for Texans to purchase private long-term care insurance due to strict asset limits for Medicaid eligibility and required estate recovery of assets. In response, the Legislature enacted SB 22 to create a long-term care partnership program in Texas to provide the necessary incentive for Texans who can afford to purchase long-term care partnership insurance to do so. Texans who purchase long-term care partnership policies under the partnership program will be eligible for asset disregard equal to the long-term care insurance benefits that have been received to the date of Medicaid application from a partnership policy should they ever apply for Medicaid long-term care benefits. However, in order for a long-term care partnership insurance policy to be offered in Texas, a state plan amendment must meet the requirements of, and be approved under, the Deficit Reduction Act of 2005 (Pub. L. No. 109-171). This adoption implements those provisions of SB 22 that establish the state partnership program that is to be administered, implemented, and monitored by the Texas Health and Human Services Commission (HHSC) with assistance from the Texas Department of Insurance. SB 22 adds new Subchapter C to Chapter 1651 of the Insurance Code relating to the Partnership for Long-Term Care Program. The amendments and new sections of Subchapter Y are adopted to implement new Subchapter C of Chapter 1651.

In addition to amending Chapter 1651 of the Insurance Code, SB 22 also amends Chapter 32 of the Human Resources Code to add new Subchapter C, relating to the Partnership for Long-Term Care Program. Section 32.102 of the Human Resources Code requires that the Partnership for Long-Term Care Program must be consistent with provisions governing the expansion of a state long-term partnership program established under the federal Deficit Reduction Act of 2005, (DRA) Pub. L. No. 109-171. Under the DRA, a Qualified State Long-Term Care Insurance Partnership Program (Qualified Partnership) means an approved state plan amendment filed by the State Medicaid Director with the U.S. Department of Health and Human Services that provides an exemption from estate recovery in an amount equal to the benefits paid under partnership policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. Under the Qualified Partnership, individuals who purchase partnership policies can apply for Medicaid under special HHSC rules for determining financial eligibility and estate recovery. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries. This feature of the Qualified Partnership is known as "asset disregard" and the asset disregard applies to all insurance benefits received from a partnership policy. The asset disregard applies to all insurance benefits paid on a reimbursement, cash benefit basis, indemnity insurance basis, or on a "per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate" (within the meaning of §7702B(b)(2)(A) of the Internal Revenue Code). Similarly, the asset disregard applies to all insurance benefits received from a partnership policy regardless of whether such insurance benefits are for costs for long-term care that would be covered by Medicaid. The asset disregard as of any date equals the insurance benefits that have been received to that date from a partnership policy, even if additional benefits may be received in the future from a partnership policy. The asset disregard does not include the return of premium payments made upon the termination of a partnership policy (due to cancellation or death) since such payments do not represent insurance benefits.

Minimum Standards for a Long-Term Care Partnership Benefit Plan. With respect to the insurance related aspects of the Partnership for Long-Term Care Program, new §1651.104 of the Insurance Code requires the Commissioner, in consultation with the HHSC, to adopt minimum standards for a long-term care benefit plan that may qualify as an approved plan under the partnership for long-term care program. New §1651.104 also requires that the standards be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. A partnership policy is a long-term care insurance policy that satisfies all of the insurance related requirements of the DRA. The requirements of the DRA that a partnership policy must satisfy relate to federal tax law qualification, issue date, state of residence, compliance with DRA consumer requirements, inflation protection, and agent training requirements. These requirements are more fully explained in the following paragraphs.

Qualified under Federal Tax Law. Pursuant to §1917(b)(1)(C)(iii)(II) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(II)), a partnership policy must be a qualified long-term care insurance contract, as defined in §7702b(b) of the Internal Revenue Code of 1986 (26 U.S.C. §7702B(b)) issued not earlier than the effective date of the state plan amendment. Issue Date. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must not be issued earlier than the effective date of the Qualified Partnership. The issue date is the effective date of coverage under the partnership policy. Thus, for example, in the case of a certificate issued under a group insurance contract, the effective date of coverage with respect to such certificate is the issue date of the certificate. Pursuant to §1917(b)(1)(C)(iii)(VII) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)) a policy received in an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate after the effective date of the Qualified Partnership is treated as newly issued and thus is eligible for partnership policy status.

State of Residence. Pursuant to §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)), a partnership policy must cover an insured who was a resident of the State when coverage first became effective under the policy. In the case of an exchange of an existing non-partnership policy or certificate for a partnership policy or certificate, this state of residence requirement is applied based on the coverage date of the first long-term care insurance policy that was exchanged (State Medicaid Director's Letter (SMDL #06-019) July 27, 2006, issued by CMS, Supplement 8c to Attachment 2.6-A page 2 paragraph 2).

Consumer Protection Requirements. A partnership policy must meet all of the Federal consumer protection requirements specified in the DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)).

Inflation Protection. Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), a partnership policy must include at least one of the following levels of inflation protection: (i) if the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy must provide compound annual inflation protection; (ii) if the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection; and (iii) if the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection.

Agent Training Requirements. Additionally, pursuant to §1917(b)(1)(C)(iii)(V) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(V)), each individual who sells a long-term care partnership policy must complete training and demonstrate evidence of understanding partnership policies and how they relate to other public and private coverage of long-term care. Insurers that offer partnership policies shall certify to the Commissioner that each individual who sells partnership policies for the insurer has complied with the agent training requirements. The Department's rules regulating long-term care partnership certification and continuing education course and licensee requirements were adopted by Commissioner Order No. 08-0639, dated July 14, 2008, published in the August 1, 2008, issue of the *Texas Register* (33 TexReg 6138), and effective August 5, 2008.

In response to comments received on the published proposal for this rule, the Department has revised some of the proposed text in the published rule. Additionally, this adoption includes minor clarification changes to several proposed provisions. None of the changes made to the proposed text, either as a result of comments or as a result of necessary clarification, materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Changes in the Proposed Text in Response to Comments. The Department received numerous comments on the proposed text. The following changes have been made to the proposed text as a result of those comments.

Exemptions from certain requirements. Three sections have been modified in the adoption in response to comments that there are various consumer protection requirements in the proposed text that do not apply to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. These sections are: (i) §3.3837(f) (Suitability Data Reporting Requirements), (ii) §3.3842 (Appropriateness of Recommended Purchase), and (iii) §3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits). Exemption from the Requirement to Offer Inflation Protection. Section 3.3860 and the definition of "long-term care partnership insurance policy" in §3.3804(21) have been revised in the adoption in response to comments to exempt life insurance policies or riders containing accelerated long-term care benefits from the offering of inflation protection. Commenters recommended that this exemption, which is substantially similar to §13C of the NAIC Long-Term Care Insurance Model Regulations, be added to §3.3820. The Department agrees that certain "life insurance policies or riders containing accelerated long-term care benefits" should be exempt from the §3.3820 requirement to offer inflation protection. Existing §3.3820, however, was not proposed for amendment in the proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635). Therefore, no substantive change may be made to existing §3.3820. In lieu of adding the requested exemption language to §3.3820, the Department is adopting: (i) an addition to §3.3860 to address the requested exemption; and (ii) a clarification addition to the §3.3804(21) definition of "long-term care partnership insurance policy." New §3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. Section 3.3860(a) specifies that a policy summary must be provided with a life insurance policy or annuity contract that provides long-term care benefits by rider. Section 3.3860(a)(4) requires that the policy summary for this type of policy contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under this policy. The definition in §3.3804(21) defines a "long-term care partnership insurance policy" as a long-term care insurance policy that is established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005, Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code. Chapter 32, Subchapter C of the Human Resources Code addresses the establishment and operation of the Partnership for Long-Term Care Program in Texas. A life insurance policy or annuity contract that provides long-term care benefits by rider does not comply with the definition of "long-term care partnership insurance policy" in proposed §3.3804(21). A partnership policy must contain an inflation protection provision as required by §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)). The DRA inflation protection provision is implemented in new §3.3872 (relating to long-term care partnership policies and certificates). Section 1651.104 of the Insurance Code requires that a long-term care partnership policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Section 3.3860 is consistent with the §6J and §6K requirements. It is also consistent with the definition of "long-term care partnership insurance policy" in §3.3804(21). Section 3.3820 addresses the requirement to offer inflation protection to all applicants for long-term care insurance. Therefore, to address the commenter's recommendation relating to the §3.3820 exemption, the Department is adopting an addition to proposed new §3.3860. A new subsection (d) is added to adopted §3.3860 to read: "The statement required in subsection (a)(4) of this section applies to: (1) life insurance policies (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and (B) that provide the option of a lump-sum payment for those benefits, and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care; and (2) riders for group and individual annuities and life insurance policies that provide long-term care insurance." In addition, for purposes of clarity and consistency, the following provision is added to the adopted §3.3804(21) definition of "long-term care partnership insurance policy": "This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider." This addition

simply clarifies the §3.3804(21) definition and is consistent with §3.3860(a)(4) and (d).

Exemption from Other Requirements. Section 3.3837(f) (Suitability Data Reporting Requirements), §3.3842 (Appropriateness of Recommended Purchase), and §3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits) have been revised in the adoption in response to comments. Each of these sections as adopted exempts life policies that have acceleration riders from the requirements of each of the specified sections. Commenters stated that there are various consumer protection requirements in the proposed text that do not apply to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. Some commenters recommended that §3.3837(f) be modified to include the NAIC Long-Term Care Insurance Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability reporting requirements in §24H of the NAIC Long-Term Care Insurance Model Regulations. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care." Some commenters recommended that §3.3840 be modified to include the NAIC Long-Term Care Insurance Model Regulation §32B which exempts life insurance policies that accelerate benefits for long-term care from the requirement to deliver a Long-Term Care shopper's guide. The requested exemption reads: "Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under §3.3860." Some commenters recommended that §3.3842 be modified to include the NAIC Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability requirements. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care." Some commenters recommended that §3.3844 be modified to include the NAIC Model Regulation §28A which exempts life insurance forms from the nonforfeiture and contingent nonforfeiture benefits requirements. The requested exemption reads: "This section does not apply to life insurance policies or riders containing accelerated long-term care benefits." While the Department agrees with the recommended exemptions, the Department does not agree with the commenter's recommended exemption language for the sections. The recommended exemption language for §§3.3837, 3.3840, 3.3842, and 3.3844 is not consistent with the definition of "long-term care insurance" in §3.3804(20). Each of these recommended exemption provision pertains to: (i) life insurance policies that accelerate benefits for long-term care; and/or (ii) life insurance policies or riders containing accelerated long-term care benefits. In the adopted text, it is necessary to more specifically identify the policies or riders subject to the exemptions. This is necessary for consistency with the definition of "long-term care insurance" in §3.3804(20). The definition of "long-term care insurance" in §3.3804(20) provides that "long-term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Therefore, these types of life insurance policies are not defined as "long-term care insurance" for purposes of §§3.3837, 3.3840, 3.3842, and 3.3844 and are properly exempt from the long-term care consumer protection requirements in those four sections. As a result, §§3.3837(f)(2)(B), 3.3842(i), and 3.3844(h)(2) as adopted contain exemption language that is consistent with the definition of "long-term care insurance" in §3.3804(20). The definition of long-term care insurance in §3.3804(20) provides that riders for group and individual annuities and life insurance policies that provide long-term care insurance are long-term care insurance for purposes of the Subchapter Y rules, including §§3.3837, 3.3840, 3.3842, and 3.3844. Therefore, it is necessary that these types of policies be afforded the consumer protection requirements in the four sections. These types of riders cannot be subject to the requested exemption. Therefore, §§3.3837(f)(2)(A), 3.3842(k), and 3.3844(h)(1) as adopted provide that the specified requirements shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3842(k) also addresses the applicability of the §3.3840 requirement of delivery of the shopper's guide. Adopted §3.3842(k) provides that both the §3.3842 requirements relating to suitability and the delivery requirements for the shopper's guide specified in §3.3840 shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Section 3.3840, relating to the requirement of the delivery of the Long-Term Care shopper's guide, was not proposed for amendment in the proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635). Therefore, no change may be made to existing §3.3840. Instead of modifying §3.3840 to address the requested exemption, the Department is adopting an exemption in §3.3842(l) for life insurance policies that under §3.3804(20) are eligible for the exemption. The booklet entitled "Long-Term Care Insurance" published by the Texas Department of Insurance is the current "shopper's guide" in accordance with §3.3840(3). Adopted §3.3842(l) exempts from the requirement of delivery of the shopper's guide (booklet) for life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies. In accordance with the definition of "long-term care insurance" in §3.3804(20), riders for group and individual annuities and life insurance policies that provide long-term care insurance are "long-term care insurance" and cannot be exempt from the shopper's guide delivery requirement. Therefore, adopted §3.3842(k) provides that §3.3842 requirements and the delivery requirements for the shopper's guide specified in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

§3.3804(21). Definitions. The defined term in §3.3804(21) as adopted has been changed from "long-term care partnership insurance contract" to "long-term care partnership insurance policy." This change is made in response to commenters who indicated that the term "long-term care partnership insurance contract" as defined in §3.3804(21) is not used consistently through-

out the text of the rules. The commenters noted that the only time this term is used in the proposal is in §3.3874(c) and that generally, the references in the rules are to "long-term care insurance or policy." Also, for purposes of clarification, two additional changes have been made to §3.3804(21) as adopted. The adopted definition states that the term may include an individual policy and/or a certificate. The adopted definition also provides that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider. Both of these clarifications are necessary to make the definition in §3.3804(21) consistent with the other rules.

§3.3826(b) - (c). Limitations and Exclusions. Section 3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9). Section 3.3826 as proposed is not entirely consistent with NAIC Model Regulations §6B(8) and (9). The proposed text combines the prohibitions against limitations by type of provider and territorial limitations into one subsection. The Model Regulations recognize that these are two separate prohibitions. To achieve uniformity with the Model Regulations in the adopted amendment to §3.3826, the Department is revising subsection (b) to clarify that subsection (b) only applies to exclusions and limitations by type of provider. The first sentence of subsection (b) as adopted reads: "This section is not intended to prohibit exclusions and limitations by type of provider." Subsection (b) as adopted has further been changed to move the definition of "state of policy issue" from subsection (b) to new subparagraph (3) in subsection (b). To further clarify that there are separate prohibitions against limitations by type of provider and territorial limitations, subsection (c) as adopted has deleted the language "exclusions and limitations by type of provider" from subsection (c) to read: "Provisions of this section are not intended to prohibit territorial limitations." Therefore, subsection (c) as adopted conforms to the Model Regulation by limiting the scope of the subsection to only territorial limitations. These changes have been made in response to comments that the proposed language in §3.3826(b) regarding cross border limitations and exclusions is misplaced. While the commenters indicated agreement with the first sentence in §3.3826(b), they recommended that §3.3826(b)(1) and (2) be moved to new §3.3826(c)(1) and (2). While the Department agrees that the language regarding cross border limitations and exclusions is misplaced, it does not agree with the commenters' suggestion on how to correct the misplacement. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §6B of the NAIC Long-Term Care Model Regulations relating to limitations and exclusions in a long-term care policy. Therefore, §3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9).

§3.3829(b)(2)(E). Rate Increase Disclosure. The phrase "individual or group" has been deleted from §3.3829(b)(2)(E) and (E)(i) as adopted. This change has been made because the Department has determined based on comments that the inclusion of the phrase caused unnecessary confusion. The deletion is a clarification consistent with the intent of the provision and is not a substantive change. Commenters requested clarification regarding the Department's intent with respect to the addition in the proposal of the phrase "individual or group" to §3.3829(b)(2)(E). The commenters expressed their understanding that if the Personal Worksheet is being used for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases. The Department agrees with the commenters' understanding that when offering long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, when offering long-term care insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet. The Department has made changes to §3.3829(b)(8)(H) as proposed in response to a comment that requests removing the section in the Personal Worksheet titled "Questions Related to Your Needs" as proposed and replacing it with an alternative section to read as follows: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL's)-bathing, continence, dressing, eating, toileting, and moving around-prior to your long-term care benefits being paid. Do you understand this policy limitation? __YES __NO" "What type of long-term care service do you anticipate utilizing? (check all that apply) __Nursing home care __Assisted living care __Home health care __Adult day care __Hospice care __Respite care __other services Does Policy Form [insert policy form number] cover all of the services checked above? If not, which of the above mentioned services are included?

Instructions to Company: Issuer must insert policy form number and list appropriate services. If demonstrating multiple policy forms, reproduce this section separately for each form." The Department agrees in part and disagrees in part with the recommended replacement section. The Department has changed the limitations on payment of policy benefits part of the "Questions Related to Your Needs" section in the adopted rules to follow the recommendation of the commenter except that the term "trigger" that was used in the proposal is being retained in the adopted rules in lieu of the suggested change to the term "paid." In addition, the Department has changed the terminology "moving around" that was used in the proposal to the term "transferring." The reason for this change is that the term "transferring" is the properly accepted term for describing the ADL's. Therefore, the pertinent part of the notice as adopted reads: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL's)-bathing, continence, dressing, eating, toileting, and transferring--prior to your long-term care benefits being triggered." This change will clarify that cognitive impairment can also trigger long-term care benefits. The Department, however, disagrees with adding the new questions recommended by the commenter. The questions concern whether the policy form that the agent is demonstrating to the applicant covers all of the long-term care services that the applicant has checked and if not, which of the services are included in the policy. The Department also disagrees with adding the recommended Instructions to Company that would require the insurer to reproduce these questions separately for each policy form being demonstrated if multiple policy forms are being demonstrated to an applicant. These recommended additions are redundant, and the Department, therefore, does not believe that they are necessary. The Outline of Coverage, which is required to be delivered to the applicant, includes the policy or certificate number and describes the benefits provided by the policy.

New §3.3829(c). Effective Dates for Use of the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form. Section 3.3829 as proposed is changed in the adoption to add a new subsection (c) to specify the effective dates and certain other requirements for use of the Long-Term Care Insurance Personal Worksheet and the Long-Term Care Insurance Potential Rate Increase Disclosure Form and to specify procedures that will provide insurers additional time to print and distribute the new forms. New subsection (c)(1) is added to §3.3829 as adopted to provide that in lieu of the Long-Term Care Insurance Personal Worksheet specified in adopted new §3.3829(b)(8)(H), insurers may use, until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." New subsection (c)(2) is added to §3.3829 as adopted to provide that in lieu of the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) insurers may use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Additionally, new subsection (c)(2) specifies that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. New subsection (c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. New subsection (c)(4) requires that on and after January 1, 2010, all insurers must use the Long-Term Care Insurance Personal Worksheet specified in adopted new §3.3829(b)(8)(H) and the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in adopted new §3.3829(b)(8)(I) in accordance with all of the requirements for these forms that are specified in §3.3829. These changes are made in response to comments requesting that insurers have a one-year delay on use of the Personal Worksheet and the Potential Rate Increase Disclosure Form. According to the commenters, a year is needed to file the forms, have them approved, and moved into production. While the Department disagrees with the requested delay, the Department understands that additional time may be needed to print and distribute the new Personal Worksheet and the new Potential Rate Increase Disclosure Form. The Personal Worksheet provides information for the insurer to use to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet provides the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant. Delaying the use of the Personal Worksheet as requested by the commenters would deprive long-term care policy applicants of these important consumer protections for a full year. Likewise, delaying the use of the Potential Rate Increase Disclosure Form would deprive long-term care policy applicants of important information concerning rate increases on specific policy forms for a full year. Therefore, the Department is adding a new subsection (c) to §3.3829 as adopted.

§3.3842(j). Appropriateness of Recommended Purchase. Section §3.3842(j) as adopted allows insurers to send the applicant a suitability letter in accordance with or similar to the letter specified in §3.3842(j). Adopted §3.3842(j) provides in the first sentence that if the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with or similar to Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. This change is made in response to commenters who requested greater "flexibility" in the language of the proposed suitability letter specified in §3.3842(j). The commenters recommended amending the first sentence of §3.3842(j) to allow the issuer to send a letter similar to the letter specified in §3.3842(j). In addition, because of the change to the first sentence in §3.3842(j), conforming changes have been made to §3.3842(j)(1) and (2). The modified language in §3.3842(j)(1) as adopted reads: "The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in adopted new §3.3842(j) or be similar to the text specified in §3.3842(j)." Additionally, the modified language in §3.3842(j)(2) as adopted deletes the requirement that the text must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

§3.3848(a). Limited Premium Payment Requirements. Section 3.3848(a) as proposed has been changed in the adoption to add to the end of that subsection the following provision: "Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10 years and any such options are not subject to this section." Commenters asserted that it is not clear in §3.3848 that the requirements of the section apply only to policies with a payment period of 10 years or less. The commenters requested a clarifying statement to address this.

§3.3848(b)(1). Notice of Limited Premium Payment Option. Section 3.3848(b)(1) as proposed is changed in the adoption to allow for varying methods of disclosure of the notice of the limited premium payment option in limited pay period policies. Section 3.3848(b)(1) as adopted reads as follows: "Notice. A long-term care insurance policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option." The proposal required that the notice be on the face page of the policy. This change has been made in response to commenters who requested the language in §3.3848(b)(1) that is adopted.

§3.3848(b)(3), (4), and (5)(A). Requirements Concerning Single-Premium Payment Option, One-to-Four Year Premium Payment Options, and Five-to-Ten Year Premium Payment Options. Section 3.3848(b)(3), (4), and (5)(A) as adopted include the following provision: "In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page." As proposed, these provisions required that the renewability provision be on the face page of the policy or certificate. Commenters objected because the provisions did not contain an alternative that would allow the required renewability provision to be added to the policy via an endorsement or change to the schedule page. The commenters pointed out that the rule has a requirement that the Department can only approve a limited pay plan on a separate policy series. The commenters stated that under §3.3848(b) the Department is essentially continuing that same mandate by requiring disclosure on the policy cover. According to the commenters, most carriers in virtually all states implement limited pay disclosures through an endorsement on the schedule page. The commenters requested that the following language be added to the end of each of the provisions in §3.3848(3), (4) and (5)(A): "In the alternative, the required renewability provision may be added to the policy via an endorsement or change to the schedule page." The Department disagrees with this recommended change. There is no require-

ment that only a limited pay plan on a separate policy series can be approved by the Department. Insurers are permitted to offer limited pay premium by endorsement and proper disclosure on the cover page. Therefore, the Department has determined that the proper alternative is as stated in the adopted provisions.

§3.3870(a). Notification and Offer of Exchange Requirements. Section 3.3870(a) as adopted extends the requirement for insurers to implement an exchange program to 18 months from the date the insurer initiates its partnership program and limits the offer to exchange under a policy or certificate to a policy or certificate of the type certified by the insurer. Proposed §3.3870(a) required the insurer to offer the option to exchange by December 31, 2009. Proposed §3.3870(a) also required insurers to offer, on a one-time basis to all policyholders or certificate holders that were issued long-term care coverage by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. These changes are in response to commenters who requested that the requirement to offer exchanges be extended to allow insurers 18 months from the date the insurer initiates its partnership program to implement an exchange program. These commenters also requested that the offer to exchange be limited to insureds under a policy or certificate "of the type certified" by the insurer (e.g., if an insurer certifies an individual policy for partnership, certificate holders under a group policy should not be required to receive an offer of exchange for the individual partnership policy). These commenters recommended changing §3.3870(a) to read as follows: "(a) Notification and Offer of Exchange. *Within 18 months from the date that an insurer* [Any insurer that] begins to advertise, market, offer, or sell, [or issue] policies [that qualify] under the Texas Long-Term Care Partnership Program, the insurer is required to offer on a one-time basis, *in writing*, to all policyholders [and] or certificate holders that were issued long-term care coverage *of the type certified* by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. [The insurer is required to offer the option to exchange in writing by December 31, 2009.]" Adopted §3.3870(a) is consistent with the commenters' requested changes.

§3.3870(b)(2)(C). Alternative Exchange Methodology or Program. Section §3.3870(b)(2) as adopted contains a new provision in subparagraph (C) to permit insurers to develop an alternative exchange methodology or program that may differ from the procedures and requirements specified in proposed §3.3870. Proposed §3.3870(b)(2) did not provide such an alternative. It required insurers to make the new coverage available in one of the ways specified in §3.3870(b). This change is in response to commenters who recommended that insurers be allowed to develop alternative exchange programs. These commenters specifically recommended that a new subparagraph (C) be added to §3.3870(b)(2) as follows: "(C) In lieu of paragraphs (A) and (B) above, an insurer may implement an alternative exchange methodology or program so long as such methodology or program meets the intent of this section and is filed with and approved by the Commissioner." While the Department agrees with the recommendation, the Department does not agree with the specific recommended language. The recommended language is vague and lacks sufficient specificity for rule implementation and compliance enforcement. Therefore, in lieu of the recommended language, the Department has adopted the following provision in §3.3870(b)(2)(C): *In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the Department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).*

§3.3870(e). One-time Exchange Reporting Requirement. Section 3.3870(e) as adopted requires an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. Section 3.3870(e) as proposed required insurers to report exchanges made pursuant to §3.3870 on a one-time basis for the 2009 reporting period and to be reported by June 30, 2010. Some commenters objected to proposed 3.3870(e) because it required the carriers to report exchanges on the Long-Term Care Insurance Replacement and Lapse Reporting Form for calendar year 2009. According to the commenters, it is preferable to report exchanges separately because carriers will have to reprogram their replacement reporting systems for this onetime reporting requirement. Section 3.3870(a) as adopted provides each individual insurer with an 18-month time period from the date that the insurer initiates its partnership program to implement an exchange program. This modification to §3.3870(a) also requires a revision in the time frame for the reporting of exchanges specified in §3.3870(e).

§3.3871(a)(2)(B)(vii). Partnership Status Disclosure Notice. The proposed disclosure notice has been changed in the last sentence of the paragraph titled "What Could Disqualify Your Policy Status as a Partnership Policy" to delete the incorrect reference to the term "Endorsement" and to substitute the words "Disclosure Notice." This change is in response to commenters who pointed out this inadvertent error in the disclosure notice specified in adopted new §3.3871(a)(2)(B)(vii).

Other Changes to the Proposed Text. The necessary clarification and other non-substantive changes to the proposed text are described in the following.

§3.3803(a)(3). Applicability and Severability. The Department has made a change to §3.3803(a)(3) as proposed to correct the inadvertent omission of "annuity contracts" from this paragraph. The purpose of §3.3803(a)(3) is to specify the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). The proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635) inadvertently omitted the reference to "annuity contracts" in proposed §3.3803(a)(3). The Department has interpreted the §6J policy summary requirement and the §6J(4) prohibition to also apply to annuity contracts. While annuity contracts are not addressed in the NAIC Model Act §6J, the Department applies the §6J requirements to annuity contracts. There are two reasons for applying the §6J requirements to annuity contracts in Texas: (i) riders that meet the definition of long-term care are being attached to annuity contracts; and (ii) annuity products are regulated similarly to life insurance policies. Therefore, for purposes of clarity and consistency, §3.3803(a)(3) as adopted is changed to provide that §3.3860 applies not only to non-partnership life insurance policies, but also to annuity contracts, that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Section 3.3860 relates to the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Under these requirements, a policy

summary must be delivered with a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider at the same time that the policy or contract is delivered.

§3.3804(15). Definition of "home health agency." In the definition of the term "home health agency" in proposed §3.3804(15), the reference to the Texas Department of Health has been revised to reflect that the Texas Department of Health is now a part of the Texas Health and Human Services Commission. The adopted definition references the Texas Health and Human Services Commission.

§3.3804(19). Definition of "long-term care benefit plan." Two revisions have been made to the definition of "long-term care benefit plan" in §3.3804(19) as adopted. First, the second sentence of the definition has been revised to add the statutory authorization. As adopted, the sentence reads: "Pursuant to the Insurance Code §1651.003(b), the term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or for the loss of functional capacity." Second, language has been added to the definition to specify the class of life insurance policies that will not be defined as a long-term care benefit plan. The reason for this change is to clarify for the users of these rules exactly which classes of life insurance policies are and are not included in this definition. The clarifying language reads: "With regard to life insurance, this term does not include life insurance policies:

(A) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(B) that provide the option of a lump-sum payment for those benefits; and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care."

§3.3804(20). Definition of "long-term care insurance." The proposed definition of "long-term care insurance" in §3.3804(20) is reformatted in the adoption for purposes of making the definition more user friendly. While there are no substantive changes in the proposed definition, the various components of this long and complicated definition have been reformatted into subparagraphs (A) - (D). Subparagraph (A) concerns the general definition of long-term care insurance, the types of policies that may be included in the category of long-term care insurance, and the entities that are authorized to issue long-term care insurance. Subparagraph (B) concerns the types of insurance policies that contain health benefits but are not classified as long-term care insurance. Subparagraph (C) concerns certain life insurance policies that accelerate death benefits that are not classified as long-term care insurance. Subparagraph (C) is further divided into clauses (i) - (iii). Subparagraph (D) specifies that any product advertised, marketed, or offered as long-term care will be subject to the provisions to Subchapter Y.

§3.3804(21). Definition of "long-term care partnership insurance policy." The term defined in proposed §3.3804(21) was "long-term care partnership insurance contract." As a result of comments, the defined term has been changed in the adoption to "long-term care partnership insurance policy." The definition of "long-term care partnership insurance policy" is revised to include the necessary provision that the term "long-term care partnership insurance policy" does not include a life insurance policy or annuity contract that provides long-term benefits by rider. This clarification is non-substantive and is simply a re-statement of one of the principal elements of the long-term care partnership program in Texas. The re-statement in the definition is for purposes of making the definition more user friendly. This principal element is addressed in §3.3860(a)(4), (d)(1) and (2), and §3.3872(b).

§3.3849(e)(2). Initial Certification of Association's Compliance with Marketing Standards for Long-Term Care Policies and Certificates. In §3.3849(e)(2) as adopted, there is a change in the proposed time frame for the submission to the Department by insurers of Form Number LHL573(LTC), the initial Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. Adopted §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009. Section §3.3849(e)(2) as proposed required the initial certification to be submitted to the Department between January 1, 2009 and January 31, 2009, for the calendar year 2008. The proposal was based on anticipated association activity during calendar year 2008 that would be subject to the rules. However, because the rules will not be effective until some time in early calendar year 2009, there will not be any association activity subject to this rule during calendar year 2008.

§3.3871(a)(1)(D). Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates. Section 3.3871(a)(1)(D) as adopted clarifies that the effective date of the newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed. The adopted provision further clarifies that the insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer. Section 3.3871(a)(1)(D) as proposed was unclear for the following reasons: (i) it did not indicate that the partnership policies that are addressed in §3.3871(a)(1)(D) are "newly issued" policies; (ii) it did not indicate that the effective date of the partnership policy is shown on the policy schedule page; (iii) it did not state that the choice of the effective date is at the option of the insurer, and (iv) it did not provide that while the insurer has the option of using either date, the insurer must use the same option in all partnership policies issued by that insurer. While all of these elements are implied, the clarifications remove the possibility of ambiguities in the reading and interpretation of the provision that could result in inconsistent compliance. Such inconsistent compliance could result in disparate treatment of long-term care partnership policy holders and certificate holders.

§3.3872(a)(3). Inflation protection option for any person who has attained the age of 76. Section 3.3872(a)(3) as adopted clarifies that although inflation protection is not required for any applicant for a partnership policy who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any such applicants. While this requirement is implied, the clarification is necessary for purposes of making the rules relating to inflation protection in §3.3820 and §3.3872 more user friendly.

§3.3872. Inflation protection. Subsection (b) is added to §3.3872 as adopted to clarify the types of policies for which inflation protection is not available. This provision is necessary to conform §3.3872 with §3.3860(a)(4). Section 3.3860(a)(4) requires that the policy summary for the types of policies specified in §3.3872(b) contain a statement that provides that any

long-term care inflation option required by §3.3820 and §3.3872 is not available under the policy. The clarifying subsection states that the inflation protection provisions in §3.3872 are not available (1) under riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) under life insurance policies (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and (B) that provide the option of a lump-sum payment for those benefits; and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3874(c). Agent Training Certification Filing Requirements. The word "policies" has been added at the end of §3.3874(c) as adopted. The word was inadvertently omitted in proposed §3.3874(c). Adopted §3.3874(c) reads in pertinent part: "An insurer offering partnership policies or certificates in this state shall submit for the initial certification to the department . . . and how they relate to other public and private coverage of long-term care *policies*."

§3.3874(c)(1). Initial Agent Training Certification. Section 3.3874(c) specifies agent training certification filing requirements. It requires each insurer to certify that each individual who sells a long-term care benefit plan for the insurer under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership insurance contracts and how they relate to other public and private coverage of long-term care policies. Insurers are required to submit the initial certification to the Department on Form Number LHL571(LTC), Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in §3.3874(b)(6)(A) and the subsequent annual certifications to the Department on Form Number LHL572(LTC), Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B). Section 3.3874(c)(1) as adopted provides that insurers must file the initial agent training certification form, Form Number LHL571(LTC), between June 1, 2009 and June 30, 2009. Section 3.3874(c)(1) as proposed required that the initial certification Form Number LHL571(LTC) be submitted to the Department between January 1, 2009 and January 31, 2009. In addition, a conforming change is made in adopted Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form in §3.3874(b)(6)(A) to specify that the form is to be submitted to the Department by June 30, 2009 instead of January 31, 2009 as proposed. The proposal was based on the rules being effective some time in 2008 with insurers filing the certification between January 1, 2009 and January 31, 2009 for those agents receiving the training in 2008. However, because the rules will not be effective until some time in early calendar year 2009, there will not be any certification necessary under this rule for calendar year 2008. Therefore, to give insurers and agents sufficient time for preparation to comply with the training and certification requirements, adopted §3.3874(c)(1) provides that insurers must file the initial agent training certification form, Form Number LHL571(LTC), between June 1, 2009 and June 30, 2009. There are no changes to Form Number LHL572(LTC), Long-Term Care Partnership Agent Training Certification Form, specified in §3.3874(b)(6)(B) for the annual certification.

Change of "title" to "subchapter." The incorrect reference to "title" has been changed to "subchapter" in the following sections as adopted: §§3.3826(a)(1), 3.3829(a)(1), 3.3829(a)(9), 3.3830(g), 3.3844(d)(6), and 3.3844(d)(8).

Section-by-Section Summary. The following is a section-by-section summary of the adopted amendments and new sections and the reasons for the adoption.

§3.3802. Purpose. The adopted amendments to §3.3802 divide the existing section into six paragraphs and add new paragraph (7) to state the new purpose relating to the long-term care partnership program. Paragraph (7) provides that the new purpose is to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care partnership benefit plan as required in SB 22, codified as §1651.104 of the Insurance Code.

§3.3803. Applicability and Severability. The adopted amendments to §3.3803 amend the title of the section to remove the word "Scope" and add the word "Severability." This is necessary because §3.3850 (pertaining to Severability) has been repealed and the severability provisions have been relocated without change to §3.3803(b). The new subsection (a)(1) specifies that §§3.3801 - 3.3804 (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under Subchapter Y of Chapter 3. The introductory paragraph to existing §3.3803 is adopted to be redesignated as subsection (a)(2). The adopted amendments to the newly designated subsection (a)(2) specify that §§3.3805 - 3.3807, 3.3810, 3.3812, 3.3815, and 3.3818 - 3.3849 (relating to Non-Partnership and Partnership Long-Term Care Insurance) apply to non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state, except as specified in §3.3803(a)(5). Adopted new §3.3803(a)(3) specifies the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Adopted new §3.3803(a)(4) specifies that §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 except as specified in §3.3803(a)(5). The existing provisions in §3.3803(1) and (2), relating to policies and certificates that are not subject to the requirements of the subchapter, are re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is re-designated as §3.3803(a)(5)(B), is amended to clarify that certificates as well as policies that are not designed, advertised, marketed, or offered as long-term care or nursing home insurance are not subject to regulation under the subchapter. These amendments to §3.3803 are necessary to clarify the different types of policies and certificates that are being regulated under Subchapter Y and to specify which specific provisions in Subchapter Y apply to the various types of policies and certificates being regulated for purposes of clarity, implementation, and compliance. The adopted amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions that are being repealed. The adopted repeal is also published in this issue of the *Texas Register.*

§3.3804. Definitions. The adopted amendments to §3.3804 add new paragraph (19) to include a definition of "long-term care benefit plan," a term that is used frequently throughout the subchapter. This definition is consistent with the definition in §1651.003 of the Insurance Code. The adopted definition also specifies the class of life insurance policies that are not defined as a long-term care benefit plan. The adopted definition provides that with re-

gard to life insurance, the term "long-term care benefit plan" does not include life insurance policies: (A) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and (B) that provide the option of a lump-sum payment for those benefits; and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Amendments are adopted to existing §3.3804(19), which is redesignated as paragraph (20). The adopted amendments to re-designated §3.3804(20) change the term from "long-term care insurance contract" to "long-term care insurance" to conform the term to the term used in the NAIC Model Regulations and Model Act. Adopted §3.3804(20) defines "long-term care insurance" as that term is defined by the NAIC but as modified for consistency with §1651.003 of the Insurance Code. Most of the existing and proposed regulations in Subchapter Y are based on the NAIC Model Regulations and Model Act. In §1651.003, the term long-term care benefit plan "includes a plan or rider other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or loss of functional capacity" (emphasis added). The underlined language excludes a group or individual annuity or life insurance policy from being classified as long-term care insurance even if it provides for payment of benefits based on cognitive impairment or loss of functional capacity. Therefore, in order to conform the definition of "long-term care insurance" in Subchapter Y with the NAIC definition and for consistency with §1651.003 of the Insurance Code the definition is modified to specify that "the term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance." To conform the adopted §3.3804(20) definition of "long-term care insurance" to the NAIC definition, the following requirements are added: (i) the term includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and (ii) long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations to the extent they are authorized to issue life or health insurance. Additionally, an amendment is adopted to specify that the term long-term care insurance does not include life insurance policies that accelerate death benefits for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for benefits is conditioned upon the receipt of long-term care. The adopted definition of "long-term care insurance" is reformatted into subparagraphs (A) - (D). Additionally, the components of subparagraph (C) are further divided into clauses (i) - (iii). The reformatting is necessary to make this definition more user friendly. Subparagraph (A) concerns the general definition of long-term care insurance, the types of policies that may be included in the category of long-term care insurance, and the entities that are authorized to issue long-term care insurance. Subparagraph (B) concerns the types of insurance policies that contain health benefits but are not classified as long-term care insurance. Subparagraph (C) concerns certain life insurance policies that accelerate death benefits that are not classified as long-term care insurance. Subparagraph (D) specifies that any product advertised, marketed, or offered as long-term care will be subject to the provisions to Subchapter Y.

The adopted amendments to §3.3804 add new paragraph (21) to include a definition of "long-term care insurance partnership policy." The adopted definition provides that the term may include an individual policy and/or a certificate. The adopted definition also provides that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider. Adopted §3.3804(21) defines "long-term care insurance partnership policy" to mean a long-term care insurance policy established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005, Pub. L. No. 109-171 and the Insurance Code Chapter 1651 Subchapter C. This new definition is necessary to clarify what constitutes a long-term care partnership insurance policy under the adopted amendments to Subchapter Y. The adopted amendments are necessary to implement the requirement in SB 22 that the Commissioner, in consultation with the Health and Human Services Commission, adopt minimum standards for a long-term care benefit plan that will qualify as an approved plan under the partnership for long-term care program. In addition, in the adoption, paragraphs (20) - (30) are redesignated as paragraphs (22) - (32).

§3.3826. Limitations and Exclusions. The adopted amendments to §3.3826: (i) add new paragraph (6) to subsection (a) to permit exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy; (ii) clarify the applicability of §3.3826(b); and (iii) relocate the definition of "state of policy issue" from subsection (b) to a new subparagraph (b)(3); and (iv) clarify in §3.3826(c) that the provisions of §3.3826 are not intended to prohibit territorial limitations." Section 3.3826(b) as adopted clarifies that subsection (b) only applies to exclusions and limitations by type of provider. The first sentence of subsection (b) as adopted reads: *This section is not intended to prohibit exclusions and limitations by type of provider.* Section 3.3826(b)(3) as adopted specifies the definition of "state of policy issue." Section 3.3826(c) as adopted provides that the provisions of §3.3826 are not intended to prohibit territorial limitations. This change to §3.3826(c) is necessary to conform the rules to the NAIC Model Regulation by limiting the scope of the subsection to only territorial limitations.

§3.3829. Required Disclosures. The adopted amendments to §3.3829(b)(2) specify the two disclosure forms that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate. The two disclosure forms are Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Adopted §3.3829(b)(2)(E) and (E)(i) as adopted are the same as existing §3.3829(b)(2)(E) and (E)(i). The proposed amendments to specifically identify the policy form or similar policy forms as "individual or group" policy forms are not adopted. This is because some commenters requested clarification regarding the Department's intent with respect to the addition in the proposal of the phrase "individual or group" to existing §3.3829(b)(2)(E) and (E)(i). The commenters expressed their understanding that if the Personal Worksheet is being used for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases. The Department agrees with the commenters' understanding that for offerings of long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, for offerings of long-term care

insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market. Therefore, because the proposed amendments caused unnecessary confusion, the Department has deleted the phrase from §3.3829(b)(2)(E) and (E)(i) as adopted. This deletion does not result in any substantive change to §3.3829(b)(2)(E) and (E)(i). Adopted §3.3829(b)(2)(E) and (E)(i) require that the information regarding each premium rate increase on the policy form or similar policy forms over the past 10 years for this state or any other state must at a minimum, identify the policy forms for which premium rates have been increased.

Adopted amendments to §3.3829(b)(8) specify the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subsection (b)(8)(H). A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subsection (b)(8)(I). New Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet requires the insurer to obtain detailed information from the individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, and also a disclosure of the insurer's rate history, and right to increase premiums. This form will assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy. New Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. The amendments to §3.3829 are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104 which requires that a partnership policy be consistent with provisions established under the DRA. The DRA requires a partnership policy to conform to specific consumer protection provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC consumer protection requirements for partnership policies include the provisions of §9 of the NAIC Long-Term Care Model Regulations, which pertain to Required Disclosures of Rating Practices to Consumers, and included in §9 is the requirement to use the new forms specified in §3.3829(b)(8)(H) and (I). These consumer protection provisions, which are required under the DRA, are necessary to require the use of these new forms in the marketing of long-term care policies. The adopted amendments to §3.3829(b)(2) add a new section to the Personal Worksheet titled "Questions Related to Your Needs." This new section explains that one must be diagnosed with cognitive impairment or be unable to perform two of the six specified activities of daily living (ADL's) prior to long-term care benefits being triggered. The six activities are bathing, continence, dressing, eating, toileting, and transferring - prior to your long-term care benefits being triggered. The new section asks the applicant if the applicant understands this policy limitation. The next question is "What type of long-term care service do you anticipate utilizing?" and asks the applicant to check all that apply. The listed services are: (i) Nursing home care; (ii) Assisted living care; (iii) Home health care; (iv) Adult day care; (v) Hospice care; (vi) Respite care; and (vii) other services. The new section to the Personal Worksheet titled "Questions Related to Your Needs" adds consumer protection requirements in the form of additional disclosure statements and questions to Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet. These disclosure statements and questions are listed in the part of the form titled "Questions Related to Your Needs" and include disclosure statements and questions to applicants regarding: (i) awareness of the term "cognitive impairment" and the need for such a diagnosis to trigger benefits; (ii) awareness of ADL's and number of the ADL's that an applicant must be unable to perform to trigger long-term care benefits; (iii) a question concerning the applicant's understanding of policy limitations; and (iv) what type of long-term care service the applicant anticipates utilizing. These additional disclosure statements and questions are necessary to more prominently disclose some of the most important limitations that are currently contained in long-term care policies.

Adopted new §3.3829(c) specifies the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I). Adopted new §3.3829(c) is necessary to provide sufficient time to insurers to print and distribute the new forms. Adopted §3.3829(c)(1) provides that in lieu of the Long-Term Care Insurance Personal Worksheet specified in §3.3829(b)(8)(H), insurers may use, until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." Adopted to §3.3829(c)(2) provides that in lieu of the Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) insurers may use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Additionally, adopted §3.3829(c)(2) specifies that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. Adopted §3.3829(c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. Adopted §3.3829(c)(4) requires that on and after January 1, 2010, all insurers must use Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) in accordance with all of the requirements for these forms that are specified in §3.3829. The Personal Worksheet is necessary to provide information for the insurer to use to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet is necessary to provide the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant.

§3.3830. Requirements for Application Forms and Replacement Coverage. The adopted amendment to §3.3830 adds new subsection (h). This new subsection requires that if a long-term care policy is being replaced by a life insurance policy with a long-term care rider that accelerates life insurance benefits to cover the cost of long-term care, the sale of the replacement policy must comply with all of the requirements of §3.3830. Ad-

ditionally, if the policy being replaced is a life insurance policy, the insurer must comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), and Chapter 3 Subchapter NN (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the Department pursuant to the Insurance Code Chapter 1114. Further, if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer must comply with §3.3830, Chapter 3, Subchapter NN, and the Insurance Code Chapter 1114. This amendment is necessary to implement the provisions of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §14 of the NAIC Long-Term Care Model Regulations relating to Requirements for Application Forms and Replacement Coverage. These §14 provisions are included in adopted new §3.3830(h).

§3.3837. Reporting Requirements. The adopted amendments to §3.3837 amend subsection (a) by adding new provisions to specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. Existing §3.3837(a) is re-designated as subsection (a)(1)(A). The adopted amendments to §3.3837 divide existing subsection (a) into subsection (a)(1) relating to agent records; this is existing subsection (a); subsection (a)(2) relating to reporting of 10 percent of agents; this is existing subsection (a)(1) with adopted amendments; subsection (a)(3) relating to reporting the number of lapsed long-term care policies; this is existing subsection (a)(3) with adopted amendments; and subsection (a)(4) reporting number of replacement long-term care policies; this is existing subsection (a)(4) with adopted amendments. Existing §3.3837(a)(2) is moved to new subsection (a)(1)(B) without changes; it provides that the purpose of the replacement and lapse reports is to review more closely agent activities regarding the sale of long-term care insurance and that reported replacement and lapse rates do not alone constitute a violation of insurance laws. Amendments to subsection (a)(2), pertaining to reporting of 10 percent of agents, are adopted to specify that each insurer shall report the information in accordance with the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form concerning the 10 percent of the insurer's agents with the greatest percentages of policy or certificate lapses or replacements during the preceding calendar year and that insurers must submit the required information in an electronic format prescribed by the Department. Form Number LHL562(LTC) specifies the data elements that insurers will be required to report for such lapses and replacements. Specifically, each insurer must maintain records for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of replacements and for each agent that is in the 10 percent of that insurer's agents with the greatest percentage of lapses. The adopted form requires information on each agent's name, number of policies sold by the agent, number of policies replaced and lapsed by the agent, and number of replacements and lapses as percent of number of policies sold by the agent. The adopted amendments to §3.3837 further amend subsection (a)(3) and (4) to require insurers to use the part of Form Number LHL562(LTC) relating to Company Totals to comply with the reporting requirements in subsection (a)(3) and (4). The data that insurers are required to report under subsection (a)(3) and (4) are insurance company totals for the number of lapsed and replacement long-term care policies sold as a percentage of its total number of long-term care policies in force as of the end of the preceding year. Under the adopted amendments to subsection (a)(3) and (4), the required information must be submitted electronically in a format prescribed by the Department. The adopted amendments to §3.3837(a)(1), (2), (3), and (4) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. This section requires that a partnership policy be consistent with the provisions established under the DRA. The DRA requires a partnership policy to conform with specific reporting requirement provisions of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Model Regulations and Model Act. These NAIC reporting requirements for partnership policies include the provisions of §15 of the NAIC Long-Term Care Model Regulations, which pertain to Reporting Requirements. Section 15 requires insurers to use the new form specified in §3.3837(a)(2) to report the data specified in adopted amendments to subsection (a)(1), (2), (3), and (4). Existing §3.3837(a)(5) has been deleted because the requirement for reporting of the annual rate filings required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) is moved to new §3.3837(g) for purposes of organizational clarity.

The adopted amendments to §3.3837(b), pertaining to insurer reporting requirements relating to rescissions, are necessary to require the use of Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies specified in §3.3837(b) in lieu of existing form LTC RESCIND that is currently adopted by reference in §3.3848. The existing form is included in §3.3837(b) with a new form number but without changes to the form requirements. The adoption by reference of the LTC RESCIND form in existing §3.3848 is repealed, and the adopted repeal is also published in this edition of the *Texas Register.* The adopted amendments to §3.3837(b) clarify that each insurer must report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. The new Form Number LHL563(LTC), consistent with existing form LTC RESCIND, requires each insurer to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. Under the adopted amendments to §3.3837(b), the required information in new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the Department. The adopted amendments to §3.3837(b), including the new Form Number LHL563(LTC), are necessary to place all of the insurer reporting requirements in the subchapter in §3.3837. This will result in more efficient organization and greater clarity that will facilitate implementation, compliance, and enforcement of the rules.

The adopted amendments to §3.3837(c), pertaining to reporting requirements for claims denied by class of business, add new paragraph (1) to include the definitions of the terms "claim" and "denied" when those terms are used in the subsection. Amendments to subsection (c) are also adopted to require insurers to use adopted new Form Number LHL564(LTC) Long-Term Care Claim Denials Reporting Form, which is specified in §3.3837(c)(2), to comply with the reporting requirements in subsection (c)(2). Under the adopted amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and number of claims not paid due to waiting period not being met. The adopted amendments to §3.3837(c)(2) require the data in Form Number LHL564(LTC) to be submitted electronically in a format prescribed on the Department's website. The amendments to §3.3837(c)(2) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §15 of the NAIC Long-Term Care Model Regulations, relating to Reporting Requirements. Section 15 contains the requirement that insurers must report state and nationwide data relating to claim denials in accordance with the adopted new form specified in §3.3837(c)(2). The adopted amendments to §3.3837(d), pertaining to reporting requirements for the long-term care partnership program, delete the existing subsection (d) and adopt new reporting requirements for all insurers that market partnership policies in Texas. New §3.3837(d) requires that each insurer report to the Department by June 30 of each year the information required in §32.107 of the Human Resources Code. Each insurer must specify the number of approved partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The information required in subsection (d) must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires the Texas Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling HHSC requirements under §32.107 of the Human Resources Code. Existing §3.3837(d) specifies that the reporting requirements in §3.3837 relate only to long-term care insurance delivered or issued for delivery in this state; this provision is redundant of adopted new provisions in §3.3837 and is deleted.

The adopted amendments to §3.3837, pertaining to reporting requirements for both partnership and non-partnership plans, add new subsection (e) to require that all insurers that market long-term care insurance in Texas report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans during the preceding calendar year. The information required in adopted new subsection (e) must be reported in accordance with Form Number LHL565(LTC) as specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. New §3.3837(e) is necessary to implement the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. Therefore, the Department has determined that the most effective approach to measuring the progress of the partnership program in Texas is to compare partnership data as required pursuant to adopted §3.3837(d) and non-partnership data as required pursuant to adopted §3.3837(e). In order to provide a meaningful, comprehensive report on the progress of the partnership program to the Legislature, it is necessary that insurers report the non-partnership data specified in adopted new §3.3837(e) as well as the partnership data specified in the adopted amendments to §3.3837(d). The Department is authorized to require non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Subchapter C of Chapter 1651 specifies the Department's regulatory functions with regard to the long-term care partnership program. While the Human Resources Code §32.107(a) requires the HHSC to submit the biennial report on the progress of the partnership program, any information that may be requested of the Department as provided in §32.107(b) of the Human Resources Code would have to be requested from insurers pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004.

Adopted new §3.3837(f) provides new suitability reporting requirements for all insurers that market long-term care insurance policies in Texas. Insurers are required to provide suitability data on non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in new Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in §3.3837(f)(1). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the new requirements, insurers are required to report suitability data for long-term care partnership

comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a suitability letter. Adopted new §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. Adopted §3.3837(f)(1) specifies the representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form. Adopted §3.3832(f)(2) is necessary to clarify the types of policies that are exempt from the requirements of §3.3837(f). Section 3.3837(f)(2)(A) provides that subsection (f) applies to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Section 3.3837(f)(2)(B) exempts from the requirements of §3.3837(f) life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. New §3.3837(f) requirements for reporting suitability data for partnership policies sold in Texas are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. Section 24 contains the requirement that insurers must report the long-term care partnership data specified in adopted new §3.3837(f). New §3.3837(f) requirements for reporting suitability data are necessary for the Department to have an understanding of what is going on in terms of the marketing practices of those insurers that market partnership policies as well as those insurers that market non-partnership policies. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The Department is authorized to require the non-partnership data from insurers under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including suitability as provided in §3.3842, which was adopted pursuant to §1651.004 of the Insurance Code for the purpose of implementing Chapter 1651. Adopted new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing required under former Insurance Code Article 3.70-12 §4(b) (revised as Insurance Code §1651.053(c) as part of the non-substantive Insurance Code revision) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Existing §3.3837(a)(5) is redesignated as new §3.3837(g). Adopted §3.3837(g) clarifies that the demonstration of compliance with applicable loss ratio standards that is in the current rule is in addition to any demonstration required under §3.3831(c)(2)(B) - (D). Adopted §3.3837(g) also mandates that compliance with the statutory requirement includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The requirements in re-designated §3.3837(g) are necessary to clarify the information a company must provide in order to demonstrate compliance with the Insurance Code §1651.053(c)(1).

§3.3838. Filing Requirements for Advertising. The adopted amendments to §3.3838(1) refine the requirements for the advertising of partnership and non-partnership long-term care insurance to exclude the necessity of filing institutional advertisements (as that term is defined in 28 TAC §21.102 (relating to Scope)) if the advertisement only references long-term care insurance as a line of coverage. Institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer continues to be subject to prior approval by the Commissioner, subject to the requirements in existing §3.3838. The adopted amendments to §3.3838(1) are necessary to exclude from the filing and review requirements long-term care insurance advertisements that do not provide any details on the long-term care insurance product. Because these advertisements are not currently a source of false, misleading, or deceptive marketing practices, the Department has determined that the Commissioner's review is not necessary. The result will be more efficient and cost-effective advertising filing requirements for long-term care insurers. Also, the reduction in the number of institutional advertisements that are filed with the Department for review will enable the Department to more effectively utilize Departmental resources without compromising consumer protection. The Department will be able to redirect its resources to advertising practices that are a more frequent source of false, misleading, or deceptive marketing practices. There are no changes to existing §3.3838(2) and (3). The amendments to §3.3838(1), which apply to both partnership and non-partnership policies, are not required by SB 22 or any other state or federal legislation but rather are adopted pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3839. Standards for Marketing. Section 3.3839 specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Adopted new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insur-

ance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of application an explanation of the contingent nonforfeiture benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care Insurance Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). These new requirements ensure that more consumers are better informed about the availability of the senior insurance counseling program and therefore, more consumers will participate in the counseling program. The Health Information Counseling and Advocacy Program of Texas is the senior counseling program and is operated by the Department. The program provides consumer information on long-term care insurance, including planning, insurance basics, need for such coverage, costs, and methods of financing. This information means that more consumers are able to make more informed decisions regarding the purchase of long-term care insurance. Also, more consumers are better informed about the contingent nonforfeiture benefit on lapse provisions, including the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods. A contingent nonforfeiture benefit upon lapse allows the insured to either choose a reduced benefit amount to prevent premium increases or to convert their policy to a paid-up status. The required information explains the different contingent nonforfeiture benefit on lapse options that are available to a consumer if the consumer decides to allow their long-term care policy to lapse within 120 days of a substantial rate increase. With such information, more consumers are aware of the possible range of benefits that they have in the event that they are unwilling or unable to pay the long-term care premium in the face of a substantial rate increase by the insurer. This type of information also assists consumers in making more informed decisions regarding the purchase of long-term care insurance.

As previously stated, the required use of these new forms, which is also required under adopted §3.3829, provides additional information obtained from the applicant to assist the insurer and the applicant to make an informed decision on whether it is prudent for the applicant to purchase the long-term care policy given the financial circumstances of the applicant. This ensures that those consumers who do not need or cannot afford such a policy will be less likely to purchase one. Additionally, for marketing standards purposes, each agent marketing long-term care insurance will have information pertaining to each applicant or potential applicant that will enable the agent to identify those individuals who are financially suitable to purchase such insurance.

The adopted amendments to §3.3839 provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions.

Existing §3.3839(b), which is redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are adopted to the existing required notices or to the existing requirements for providing the notice to policyholders. The redesignation of existing §3.3839(b)(1) and (2) as §3.3839(a)(11)(A) and (B) is necessary to clarify that the required notices in existing §3.3839(b)(1) and (2) are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. The adopted amendments to §3.3839, as applicable to partnership policies, are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Section 23 contains the requirements specified in the adopted amendments to §3.3839. Section 23 A(5) requires each long-term care insurer to establish an auditable procedure for verifying compliance with all marketing procedures, including the required notices that are specified in redesignated §3.3839(a)(11)(A) and (B). The Department has determined that it is also necessary to apply the consumer protection requirements in the adopted amendments to §3.3839 to policyholders and applicants for all long-term care insurance policies, not just partnership policies. The Department has determined that prospective policyholders and applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the amendments to the §3.3839 requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

Adopted new §3.3839(a)(8), (9) and (10) and the adopted amendments to existing §3.3839(b), which provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance, implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These

NAIC consumer protection requirements for partnership policies include the provisions of §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. Included in §23 are the requirements specified in adopted new §3.3839(a)(8), (9) and (10) and the adopted amendments to existing §3.3839(b) that provide that the required inflation notices are also marketing procedure requirements that are subject to Department audit to verify compliance.

Existing §3.3839(c) and (d) are redesignated as §3.3839(b) and (c) because of the redesignation of existing §3.3839(b) as §3.3839(a)(11).

§3.3842. Appropriateness of Recommended Purchase. Existing §3.3842 provides that in recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This requirement, which is redesignated as §3.3842(a), constitutes the entirety of existing §3.3842. The adopted amendments to §3.3842 add several new requirements in adopted subsections (b) - (l) relating to the suitability standards of the insurer, health service plan, or other entity (issuer) marketing long-term care insurance. These requirements apply to both partnership and non-partnership long-term care insurance coverage. Adopted new §3.3842(b)(1) - (3) requires that each issuer develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the applicant, train its agents in the use of the issuer's suitability standards, and maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Adopted new §3.3842(c) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. These procedures must consider the following factors: (i) the applicant's ability to pay for the proposed coverage and other pertinent financial information; (ii) the applicant's goals and needs with respect to long-term care; and (iii) the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Adopted new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in adopted new §3.3842(c) and that the efforts shall include presentation to the applicant of the Long-Term Care Insurance Personal Worksheet that is adopted in new Form Number LHL560(LTC) specified in §3.3829(b)(8)(H). Under new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional information, the issuer must comply with the following requirements that are specified in new §3.3842(d)(1) - (3): (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Adopted new §3.3842(e) requires the completed Long-Term Care Insurance Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance. Adopted new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Insurance Personal Worksheet. Adopted new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Adopted new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Adopted new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the new disclosure Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form will help the applicant decide whether or not it is prudent to purchase a long-term care policy. Additionally, adopted new §3.3842(i)(1) - (6) specify the requirements and procedures that apply to adopted new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is in §3.3842(i)(7).

Adopted new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the adopted subsection provides that the insurer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with or similar to the new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the personal worksheet and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. Adopted §3.3842(k) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3842(l) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 do not apply to life insurance policies: (1) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (2) that provide the option of a lump-sum payment for those benefits and (3) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. New §3.3842(k) and

(l) are necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

Adopted new §3.3842(b) - (l) are necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions of §24 of the NAIC Long-Term Care Model Regulations, which pertain to Suitability. These §24 requirements are specified in adopted new §3.3842(b) - (j). Section 24 requires the use of the disclosure form LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance that is specified in §3.3842(i)(7) and the Suitability Letter specified in new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter as represented in §3.3842(j). The Department has determined that it is also necessary to apply the consumer protection requirements in new §3.3842(b) - (h) to issuers and their agents who market non-partnership long-term care policies, not just partnership policies. The Department has determined that applicants for non-partnership policies are entitled to the same consumer protections as those for partnership policies. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance, the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants. The Department is authorized to adopt the new §3.3842(b) - (h) requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits. Existing §3.3844, pertaining to nonforfeiture and contingent benefits in long-term care policies and certificates, addresses: (i) requirements for the offering of nonforfeiture benefits and the provision of contingent benefits upon lapse in subsection (a); (ii) requirements for nonforfeiture benefit provisions in subsection (b); (iii) requirements for nonforfeiture benefit options in subsection (c); (iv) nonforfeiture and contingent benefit standards/requirements in subsection (d); (v) requirements for insurers offering a shortened benefit period in subsection (e); (vi) required disclosure of nonforfeiture benefits in subsection (f); and (vii) requirements for contingent nonforfeiture benefits in subsection (g). No changes are adopted to existing §3.3844(a), (b), (d), or (f). An adopted amendment to §3.3844(c)(3) corrects the erroneous word "shorten" to read "shortened." No changes are made to §3.3844(g)(1); however, a new §3.3844(g)(2) is adopted.

Adopted new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with a limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium specified in the table in §3.3844(g)(2). This shall be based on: (i) the insured's issue age; (ii) the policy or certificate lapsing within 120 days of the due date of the premium so increased; and (iii) the ratio specified in adopted §3.3844(g)(4)(B) is 40 percent or more. Adopted §3.3844(g)(2) also provides that unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and (2) and are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid. The revised contingent nonforfeiture benefit on lapse provision for policies with limited premium payment periods are necessary to require insurers to include these protections in their policies. It is in the best interest of consumers who purchase policies on such payment plans to be able to receive greater protections if their policies lapse. The reasons for this are the following. The contingent nonforfeiture benefit on lapse is triggered every time an insurer increases the premium rate to a level that corresponds to the issue age of the insured at the time of the rate increase and the corresponding percent increase over the initial premium that the insured paid. Once the policyholder receives notice of a substantial rate increase the policyholder has 120 days to either pay the substantial rate increase or allow the policy to lapse and choose from the insurer's offer to: (i) reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; or (ii) convert the coverage to a paid-up policy with a shortened benefit period. Therefore, the contingent nonforfeiture benefit on lapse provisions provide a safety net to policyholders who are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Adopted new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period.

Adopted new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B). The adopted amendments to §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). The amendments also provide that subsection §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2). Adopted §3.3844(g)(2) provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results

in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The addition of this revised contingent nonforfeiture benefit on lapse provision will provide consumers with greater protections if their policies lapse. This provision ensures that, in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years. Adopted §3.3844(h)(1) provides that §3.3844 applies to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3844(h)(2) provides that §3.3844 does not apply to life insurance policies: (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and (B) that provide the option of a lump-sum payment for those benefits; and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. New §3.3844(h)(1) and (2) are necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

The adopted amendments to §3.3844 that amend subsection (e), add new paragraphs (2) and (4) to subsection (g), and add new subsection (h)(1) and (2) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the nonforfeiture benefit requirements in the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC nonforfeiture benefit requirements for partnership policies are in §28D(4), D(6), E, and E(1) of the NAIC Long-Term Care Model Regulations, relating to Nonforfeiture Benefit Requirements. Section 28D(4), D(6), E, and E(1) are specified in the adopted amendments to §3.3844(e), (e)(3), (g)(2), and (4).

The Department has determined that it is also necessary to apply the new contingent nonforfeiture benefit requirements for limited premium payment policies in the adopted amendments to §3.3844(e) and (g) to non-partnership policies and insureds for all long-term care insurance policies, not just partnership policies and insureds.

The application of the new nonforfeiture and contingent nonforfeiture benefit requirements to non-partnership policies and insureds is necessary to provide the same benefits to these insureds as is provided to partnership policy insureds. This is necessary to ensure that those insureds covered by non-partnership policies will also receive some benefits if they are unable to pay the higher premiums and are required to allow their policies to lapse. The Department has determined that insureds covered under non-partnership policies should receive the same consumer protections and benefits as insureds covered under partnership policies. There is no regulatory or public interest reason to exempt non-partnership policy insureds from these consumer protection requirements and benefits. To the contrary, there are significant regulatory and public interest reasons for providing all long-term care insureds the same consumer protections and benefits. Providing the same consumer protections and benefits to all long-term care insureds will mean that all long-term care insurance policyholders in Texas will be uniformly treated in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse. Like the partnership policy insured, the non-partnership policy insured will receive at least some benefits for the premiums he or she has paid in over the years. The Department's position is that in order to fulfill its regulatory functions pursuant to Chapter 1651 of the Insurance Code with regard to long-term care insurance that the same consumer protections must be afforded to both partnership and non-partnership long-term care applicants and policyholders. The Department is authorized to adopt the amendments to §3.3844(e) and (g) requirements for non-partnership policies under the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including non-partnership and partnership plans.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders. The regulatory requirements in adopted §3.3848, which apply to both partnership and non-partnership long-term care policies, govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Adopted new §3.3848(a) specifies the definition and applicability. Adopted new §3.3848(a) also provides that nothing in §3.3848 prohibits a carrier from offering premium payment duration options in excess of 10 years, and any such options are not subject to this section. Adopted new §3.3848(b) specifies the requirements for limited premium payment options in long-term care plans. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years and must comply with 28 TAC Chapter 3, Subchapter A and Subchapter Y and with the additional requirements specified in §3.3848(b).

The notice requirement in adopted new §3.3848(b)(1) requires that a long-term care insurance policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option. The adopted requirement in §3.3848(b)(2) requires that the provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in §3.3848. Adopted §3.3848(b)(3) - (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options.

Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. Adopted §3.3848(b)(3) also provides that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page. One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the

policy unless requested by the insured. Adopted §3.3848(b)(4) also provides that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

Adopted §3.3848(b)(5) specifies the requirements for five-to-ten year premium payment option policies. A long-term care policy, certificate or rider with a five-to-ten year premium payment option must be guaranteed renewable as provided in adopted §3.3807(a). Adopted §3.3848(b)(5)(A) specifies the requirements for the renewability provision on the face page of a long-term care policy or certificate. Adopted §3.3848(b)(5)(A) also specifies that in the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page. Adopted §3.3848(b)(5)(B) requires that for those policies, certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in §3.3848(b)(5)(C)(ii). Adopted §3.3848(b)(5)(C) requires those policies, certificates, and riders with a five-to-ten year premium payment option to be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Adopted §3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount.

The provisions in adopted §3.3848 are not required by SB 22 or the DRA. The adopted requirements, which apply to both partnership and non-partnership policies, are necessary to protect Texas insureds who have limited premium payment plans from unfair cancellation, nonrenewal, and return of premium practices.

New §3.3848 is adopted pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership and non-partnership plans.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies. Existing §3.3849, relating to 1997 effective dates and grace period, is repealed, and the adopted repeal is also published in this issue of the *Texas Register.* Adopted new §3.3849 specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F). A representation of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form is specified in adopted new §3.3849(e)(1)(F).

Adopted new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1).

Adopted new §3.3849(e)(1)(A) - (D) specify the requirements and procedures that apply to the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form, including text content, text font size, recommended format, and filing for approval as applicable. Adopted new §3.3849(e)(2) requires that the initial certification be submitted to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009, and thereafter be submitted annually between January 1 and January 31 for the preceding calendar year.

Adopted new §3.3849(e)(3) provides that the certification form is an informational filing pursuant to 28 TAC §3.5(b)(1) (relating to Filing Authorities and Categories) and is subject to the requirements and procedures in Chapter 3, Subchapter A. Adopted new §3.3849(e)(4) specifies where the annual completed certification form should be filed. This requirement is necessary to provide information to assist the Department in monitoring each association's compliance with the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in accordance with the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to protect association members. Additionally, the certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Adopted new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). This requirement is necessary to enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Adopted §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under §3.3849(c)(2), an association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. These new requirements are necessary to make consumers aware of factors, such as the financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively

evaluate the pros and cons of the long-term care insurance solicitation. Also, more consumers will have information to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Adopted new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. This requirement will enable the association's board of directors to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

Adopted new §3.3849(a) - (d) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §23 of the NAIC Long-Term Care Model Regulations, relating to Standards for Marketing. The provisions in adopted §3.3849(a) - (d) are consistent with the provisions in §23 in the Model Regulations. While §23 of the Model Regulations does not specifically require a certification form, §23C(8) of the Model Regulations includes the requirement that insurers make the annual certification that is adopted in §3.3849(a)(1)(C).

The Department has determined that it is also necessary to apply the consumer protection requirements in adopted new §3.3849 to insurers, their agents, and associations that market non-partnership long-term care policies, not just partnership policies. The Department has determined that members of associations being solicited for non-partnership policies should receive the same consumer protections as members of associations being solicited for partnership policies. There is no regulatory or public interest reason to exempt association member applicants for non-partnership policies from these consumer protection requirements. In fact, there are significant regulatory and public interest reasons for providing all association member applicants for long-term care coverage the same consumer protections. Providing the same consumer protections to all long-term care association member applicants will mean that all consumers who are members of associations in Texas will be uniformly protected from unscrupulous or dishonest marketing practices that can cause economic harm to the consumers.

§3.3860. Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits. Adopted new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. The adopted requirements do not apply to any long-term care partnership policy. Adopted §3.3860(a) specifies that at the time of delivery of a life insurance policy or annuity contract that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Adopted §3.3860(a) also provides requirements for policy summary delivery for direct response solicitations. Adopted §3.3860(a)(1) - (5) specify the policy summary content requirements: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Adopted §3.3860(b) provides that the provisions of the policy summary may be incorporated into a basic life insurance illustration that is required to be delivered in accordance with 28 TAC Chapter 21, Subchapter N (relating to Life Insurance Illustrations). Adopted §3.3860(c) specifies that any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status, a monthly report must be provided to the policyholder. Additionally, adopted §3.3860(c) specifies the information the monthly report is required to contain. Adopted §3.3860(d) provides that the statement required in §3.3860(a)(4) applies to: (i) riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (ii) life insurance policies that (A) accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and (B) provide the option of a lump-sum payment for those benefits; and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Adopted §3.3860(d) exempts the types of life insurance policies, annuity contracts, or riders containing accelerated long-term care benefits that are specified in §3.3860(d)(1) and (2) from the §3.3820 requirement to offer inflation protection and further provides that §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available for such policies.

The provisions in adopted §3.3860 are necessary to provide important information to the consumer to assist in determining whether to purchase a long-term care policy that is funded by a life insurance policy or annuity contract. Adopted §3.3860 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a long-term care policy that is funded by a life insurance policy or annuity contract be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The policy or annuity must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Adopted §3.3860 is consistent with the §6J and §6K requirements.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies. Adopted new §3.3870 specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy. Adopted new §3.3870(a) addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. Adopted new §3.3870(a) provides that within 18 months from the date that an insurer begins to advertise, market, offer, or sell, policies under the Texas Long-Term Care Partnership Program, the insurer is required to offer, on a one-time basis to all policyholders or certificate holders that were issued long-term care coverage of the type certified by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. Adopted new §3.3870(a) also requires that the offer be in writing.

Adopted new §3.3870(b) specifies the methods by which insurers may make the new coverage available, including: (i) by adding a rider or endorsement to the existing policy; (ii) by exchanging the existing policy or certificate for a new partnership policy or certificate; or (iii) in lieu of either of these, by implementing an alternative exchange methodology or program that is filed with the department and approved by the Commissioner. Adopted new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage. Adopted new §3.3870(b)(2)(B) specifies the conditions for exchange for new coverage that has an actuarial value of benefits exceeding the benefits of the existing coverage. Adopted new §3.3870(b)(2)(C) provides that in lieu of subparagraphs (A) and (B), an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter.

Adopted new §3.3870(c) addresses the general requirements for the exchange of an existing long-term care policy or certificate for a partnership policy or certificate. These requirements which are specified in adopted §3.3870(c)(1) - (5) are: (1) All offers of policy exchanges must be made on a nondiscriminatory basis; (2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires; (3) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831; (4) The new coverage offered must be on a currently approved form; (5) In the event of an exchange the insured shall not lose any rights, benefits, or built-up value under the original policy.

Adopted new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Adopted new §3.3870(e) imposes a one-time reporting requirement. Under adopted new §3.3870(e), an insurer is required to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program on Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form in accordance with the procedures and requirements specified in §3.3837(a)(4).

SB 22 establishes a partnership for long-term care program in Texas, and the Department is adopting minimum standards for an approved long-term care partnership benefit plan. These new partnership policies will be available upon the adoption of the new minimum standards for partnership policies. Under the DRA, policies sold prior to the establishment of the partnership program may be exchanged for partnership policies, and the terms and requirements of such policy exchanges are left to the discretion of each individual state. After careful review of the relevant issues and stakeholder input, the Department is adopting the requirements in new §3.3870 to regulate long-term care policy exchanges in Texas. The Department has determined that it is beneficial to insureds to provide them an opportunity to exchange their existing policy for a partnership policy. This exchange of existing policies for partnership policies will give Texas residents the opportunity to purchase long-term care policies that have the advantages of asset disregard and estate recovery benefits, which their existing non-partnership policies do not have.

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies. Adopted new §3.3871 applies only to long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the partnership policy must be the date that the partnership policy is issued or the date the application for the partnership policy was signed. Adopted §3.3871(a)(1)(A) - (D) are necessary to establish a Partnership Program in Texas in accordance with the DRA and SB 22 enacted by the 80th Legislature. The state Partnership Program is intended to promote consumers' purchase of long-term care insurance from insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased coverage. Adopted by the Texas Health and Human Services Commission, these special rules generally allow the individual to protect assets equal to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid liens and recoveries.

Adopted new §3.3871(a)(1)(A), (B) and (C) implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Pursuant to §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)), the partnership

policy must meet the general requirements of those sections in the DRA. Adopted §3.3871(a)(1)(A), (B) and (C) are consistent with §1917(b)(1)(C)(iii)(I), (II) and (IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I), (II), and (IV)).

Adopted §3.3871(a)(1)(D) provides that the effective date of a newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date that the application for the partnership policy was signed. The provision relating to the effective date being the date that the partnership policy is issued is consistent with the effective date provision in 42 U.S.C. §1396p, Historical and Statutory Notes, "Expansion of State Long-Term Care Partnership Program," Pub. L. 109-171, Title VI, §6021, Feb. 8, 2006, 120 Stat. 68; (a) Expansion Authority, (3) "Effective Date." The provision relating to the effective date being the date that the application for the partnership policy was signed is based on input from stakeholders. In the meetings that the Department held with stakeholders, insurer representatives indicated that some companies use the application date as the effective date of the policy. Adopted §3.3871(a)(1)(D) further clarifies that each insurer has the option of using either date, but provides that the insurer must use the same option in all partnership policies issued by that insurer.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). A representation of Form Number LHL569(LTC) (Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates) is specified in §3.3871(a)(2)(B)(vii). While new §3.3871(a)(2)(A) and (B) pertaining to the required disclosure notice are not required by SB 22 or the DRA, the Department is adopting these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004. Adopted §3.3871(a)(2)(A) and (B) are necessary to ensure that necessary information is provided to the insured to protect the insured from inadvertently losing partnership status and to inform the insured of various essential facts relating to the partnership policy. The required disclosure notice, titled "Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates provides essential information to the insured relating to certain disclosures, including: (i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). This Partnership Status Disclosure Notice is not required by SB 22 or the DRA. The disclosure notice is necessary to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy. The requirements and procedures related to the disclosure notice are necessary for the following reasons: (i) the 12-point type requirement will assist the consumer to more easily read and comprehend the information in the notice; and (ii) while the text and order of presentation of the information in the forms is mandated by the DRA, insurers will have flexibility with regard to the formatting of the forms subject to Department approval.

Adopted new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Adopted new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status. While new §3.3871(a)(2)(B)(ix) and (x) are not required by SB 22 or the DRA, the Department is adopting these provisions pursuant to the Commissioner's rulemaking authority in the Insurance Code §1651.004 to provide important information to the insured to enable the insured to retain the partnership status of the policy if possible and to explain to the insured why there has been a loss of partnership status. These provisions will help protect the insured from inadvertently losing partnership status and will provide vital information to the insured concerning any loss of partnership status by the insurer. Because of the important benefits of a partnership long-term care policy, including the advantages of asset disregard and estate recovery benefits, it is in the insured's interest to be informed about any possible loss of the partnership status of the long-term care policy. With this information, the insured may have the opportunity to take steps to either prevent the loss of partnership status or to replace the policy that has lost partnership status with another partnership policy.

Adopted new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under adopted §3.3871(b)(1) - (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Adopted new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are adopted in §3.3871(b). Adopted new §3.3871(b) is

necessary to provide Department rules that are consistent with the DRA reporting requirements for insurers that issue long-term care partnership policies. The information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the partnership program in Texas in accordance with the insurer reporting requirements established under the DRA. The Department is authorized to adopt new §3.3871 pursuant to the Insurance Code §1651.004, which authorizes the Department to adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Chapter 1651 specifies the Department's regulatory functions with regard to long-term care benefit plans, including partnership plans.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Adopted new §3.3872(a) sets forth the inflation protection requirements for long-term care partnership policies and certificates. Adopted new §3.3872(a)(1) specifies that for a person who is less than 61 years of age as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains age 61. Adopted new §3.3872(a)(1)(A) requires the insurer to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Adopted new §3.3872(a)(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Adopted new §3.3872(a)(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(a)(2). Adopted new §3.3872(a)(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Adopted new §3.3872(a)(2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Adopted new §3.3872(a)(2)(A) - (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is less than 76 years of age who has purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(a)(3). Adopted new §3.3872(a)(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Adopted new §3.3872(a)(3) clarifies that the long-term care inflation protection option specified in §3.3820 of this subchapter (relating to Requirement To Offer Inflation Protection) must be offered to any applicant for a partnership policy who has attained the age of 76. This clarification is necessary in order for users of these rules to clearly understand that although inflation protection is not required for any applicant for a partnership who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any applicant for a partnership policy who has attained the age of 76.

Adopted new §3.3872(a)(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(a)(1) and (a)(2). Adopted new §3.3872 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) includes the requirements that are adopted in §3.3872. Adopted new §3.3872(b) provides that the inflation protection provisions in §3.3872 are not available under the following policies: (1) riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) life insurance policies: (A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and (B) that provide the option of a lump-sum payment for those benefits; and (C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Adopted new §3.3872(b) is necessary to conform §3.3872 with §3.3860(a)(4). Section 3.3860(a)(4) requires that the policy summary for the types of policies specified in §3.3872(b) contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under the policy.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Adopted new §3.3873(a) specifies the prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Adopted new §3.3873(a)(1) requires that each partnership policy, certificate, or endorsement must be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and §3.3873(b) and (c) as applicable. Adopted new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Adopted new §3.3873(a)(2)(A) - (F) set forth the requirements and procedures that apply to Form Number LHL570(LTC), including text content and font size, order of information presented, format requirements, and filing and approval requirements if applicable. The adopted certification form specifies the elements of information that are required to be provided by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the

Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partnership program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Adopted new §3.3873(b) specifies the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the adopted requirements in §3.3873(b)(1) - (4), including: (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10 point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings); and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Adopted new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the adopted requirements in §3.3873(c)(1) - (6), including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings); and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

Adopted new §3.3873 is necessary to implement the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1917(b)(5)(B)(iii) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(B)(iii)) authorizes the insurance commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified Partnership") to certify to the state Medicaid agency that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. Adopted new §3.3873, including the information to be provided in the Long-Term Care Partnership Program Insurer Certification Form, is necessary to provide the Commissioner of Insurance with the information necessary to provide a certification for the policies.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. Adopted new §3.3874 specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Adopted new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of Chapter 19 of Title 28 of the Texas Administrative Code (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to January 31, 2009) must be submitted on Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Adopted new §3.3874(b) specifies the requirements and procedures that apply to Form Number LHL571(LTC) and Form Number LHL572(LTC), including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Adopted new §3.3874(c)(1) - (3) specify the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or certificates must submit: (i) Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form for the initial certification, and (ii) Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The initial certification form, Form Number

LHL571(LTC), is to be used for certification by the insurer for the initial certification period. Adopted §3.3874(c)(1) requires the initial certification Form Number LHL571(LTC) to be submitted to the Department between June 1, 2009 and June 30, 2009, and the subsequent annual certification Form Number LHL572(LTC) to be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010. This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. Insurers will file the annual certification Form Number LHL572(LTC) annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products. Adopted §3.3874(c)(2) provides that Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of Chapter 3. Adopted §3.3874(c)(3) requires any certification form submitted pursuant to §3.3874(c) to be filed with the Filings Intake Division of the Department and specifies the address. Adopted new §3.3874 implements the provision of SB 22, codified as Insurance Code §1651.104 and §1651.105. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the federal DRA. Section 1651.105 requires that each long-term care benefit plan issuer that offers a plan under the partnership for long-term care program shall certify to the Commissioner, in the form required by the Commissioner, that each individual who sells on behalf of the issuer has complied with the training requirements of §1651.105(a). Section 1917(b)(1)(C)(iii)(V) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(V)) and §1651.105 of the Insurance Code include the requirements that are adopted in §3.3874.

Update of Obsolete Statutory Citations. The Department is adopting amendments to §§3.3801, 3.3802, 3.3803, 3.3804, 3.3821, 3.3829, 3.3833, 3.3834, 3.3839, and 3.3846 to update obsolete statutory citations to the Insurance Code as a result of the non-substantive revision of the Insurance Code. Insurance Code Article 1.03A, which is referenced in §3.3801, was enacted as §36.001, in the non-substantive Insurance Code revision, Acts 1999, 76th Legislature, Chapter 101, §1, effective September 1, 1999 and amended by Acts 2003, 78th Legislature, Chapter 206, §15.01, effective June 11, 2003. Insurance Code Article 3.70-12, which is referenced in §§3.3801, 3.3802, 3.3803, and 3.3829 was enacted as Chapter 1651, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Insurance Code Article 3.70-12 §2(4), which is referenced in §3.3803, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Insurance Code Article 3.51-6 §1(a)(6), which is referenced in §3.3821, was enacted as §1251.056, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.50 §1(6), which is referenced in §3.3821, was enacted as §1131.064 in the non-substantive Insurance Code revision, Acts 2001, 77th Legislature, Chapter 1419, §2, effective June 1, 2003. Insurance Code Article 3.51-6 §1(a), which is referenced in §3.3833, was enacted as §1251.001, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 3.70-2(A)(4), which is referenced in §3.3834, was enacted as §1201.054 in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Insurance Code Article 21.21, which is referenced in §3.3839 was enacted as Chapter 541, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §2, effective April 1, 2005. Insurance Code Article 3.70-12 §2, which is referenced in §3.3839, was enacted as §1651.003, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §4, effective April 1, 2005. Article 3.51-6 §1(d)(2)(ii), which is referenced in §3.3846, was enacted as §1251.103, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005. Article 3.70-3(A)(2), which is referenced in §3.3846, was enacted as §1201.208, in the non-substantive Insurance Code revision, Acts 2003, 78th Legislature, Chapter 1274, §3, effective April 1, 2005.

HOW THE SECTIONS WILL FUNCTION.

§3.3801. Authority. The adopted amendment to §3.3801 updates obsolete Insurance Code citations as a result of the non-substantive Insurance Code revision.

§3.3802. Purpose. The adopted amendments to §3.3802 add new paragraph (7) to state the new purpose relating to the long-term care partnership program. Adopted paragraph (7) provides that the new purpose is to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care partnership benefit plan as required in SB 22, codified as §1651.104 of the Insurance Code.

§3.3803. Applicability and Severability. The adopted amendments to §3.3803 clarify the different types of policies and certificates that are being regulated under Subchapter Y and specify which specific provisions in Subchapter Y apply to the various types of policies and certificates being regulated for purposes of clarity, implementation, and compliance. The adopted amendments also specify the severability provisions. Specifically, the adopted amendments to §3.3803 amend the title of the section to read: "Applicability and Severability." Section 3.3850 (pertaining to Severability) is repealed and the severability provisions are relocated without change to §3.3803(b). New subsection (a)(1) specifies that §§3.3801 - 3.3804 (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under Subchapter Y of Chapter 3. The introductory paragraph to existing §3.3803 is adopted and re-designated as subsection (a)(2). The adopted amendments to the newly designated subsection (a)(2) specify that §§3.3805 - 3.3807, 3.3810, 3.3812, 3.3815, and 3.3818 - 3.3849 (relating to Non-partnership and Partnership Long-Term Care Insurance) apply to non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions) and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state, except as specified in §3.3803(a)(5). Additionally, adopted new subsection (a)(3) specifies that §3.3860 (relating to Policy Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Adopted new §3.3803(a)(4) specifies that §§3.3870 - 3.3874 of this subchapter (relating

to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 except as specified in §3.3803(a)(5). The existing provisions in §3.3803(1) and (2), relating to policies and certificates that are not subject to the requirements of the subchapter, are re-designated as §3.3803(a)(5)(A) and (B). Additionally, the existing provision in §3.3803(2), which is re-designated as §3.3803(a)(5)(B), clarifies that certificates as well as policies that are not designed, advertised, marketed, or offered as long-term care or nursing home insurance are not subject to regulation under the subchapter. The adopted amendments to §3.3803 also add new subsection (b) to relocate without change the existing §3.3850 severability provisions.

§3.3804. Definitions. Adopted §3.3804(19) defines the term "long-term care benefit plan." This definition is consistent with the definition in §1651.003 of the Insurance Code. The adopted definition specifies the class of life insurance

Adopted §3.3804(20) defines the term "long-term care insurance." The adopted definition specifies that "the term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance." The adopted definition specifies that (i) the term includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and (ii) long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations to the extent they are authorized to issue life or health insurance. Additionally, the adopted definition of "long-term care insurance" clarifies that the term does not include life insurance policies (i) that accelerate death benefits for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and (ii) that provide the option of a lump-sum payment for those benefits and (iii) where neither the benefits nor the eligibility for benefits is conditioned upon the receipt of long-term care. Lastly, the definition specifies that any product advertised, marketed, or offered as long-term care will be subject to the rules in Subchapter Y.

Adopted new §3.3804(21) defines the term "long-term care partnership insurance policy." This definition defines the term to mean a long-term care insurance policy established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and the Insurance Code Chapter 1651 Subchapter C. This new definition clarifies what constitutes a long-term care partnership insurance policy under the adopted amendments to Subchapter Y. The adopted amendments implement the requirement in SB 22 that the Commissioner, in consultation with the Texas Health and Human Services Commission, adopt minimum standards for a long-term care benefit plan that will qualify as an approved plan under the partnership for long-term care program. The adopted definition specifies that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider.

§3.3826. Limitations and Exclusions. Adopted §3.3826(a)(6) permits exclusions and limitations for expenses for services or items paid under another long-term care or health insurance policy. Adopted §3.3826(b) specifies that §3.3826 is not intended to prohibit exclusions and limitations by type of provider. Adopted §3.3826(b)(3) defines the phrase "state of policy issue" to mean the state in which the individual policy or certificate was originally issued.

Adopted §3.3826(c) limits the scope of the limitations and exclusions specified in §3.3826 to only territorial limitations. This limitation is consistent with NAIC Model Regulation §6B(9) that the provisions of §3.3826 are not intended to prohibit territorial limitations.

§3.3829. Required Disclosures. Adopted §3.3829(b)(2) specifies the two disclosure forms that must be provided to an applicant at the time of application or enrollment, or if the method of application does not allow for delivery at that time, the information must be provided at the time of delivery of the policy or certificate. The two disclosure forms are Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Adopted §3.3829(b)(8) specifies the requirements and procedures that apply to the two disclosure forms, including text size and content, recommended format, and filing and approval procedures as applicable. A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is specified in new subsection (b)(8)(H). A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is specified in new subsection (b)(8)(I). New Form Number LHL560(LTC) Long-Term Care Personal Worksheet requires the insurer to obtain detailed information from the individual who is considering the purchase of a long-term care policy. Such information includes the applicant's current insurance and premium payments, the applicant's income and net worth, and also a disclosure of the insurer's rate history, and right to increase premiums. New Form Number LHL561(LTC) Long-Term Care Potential Rate Increase Disclosure Form requires the insurer to provide detailed information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policy options in the event of a rate increase. Adopted §3.3829(c) specifies the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Under adopted §3.3829(c)(1), insurers are allowed to use until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." Under adopted §3.3829(c)(2), insurers are allowed to use, until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form (titled LTC RATE INCR DISC-01-2002) that is currently in use in Texas. Adopted §3.3829(c)(2) also provides that insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet. Under adopted §3.3829(c)(3), insurers are not required to file either the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. Under adopted §3.3829(c)(4), on and after January 1, 2010, all insurers are required to use adopted Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and adopted Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form in accordance with all of the requirements for these forms that are specified in §3.3829.

§3.3830. Requirements for Application Forms and Replacement Coverage. Adopted §3.3830(h) requires that if a long-term care policy is being replaced by a life insurance policy with a long-term care rider that accelerates life insurance benefits to cover the cost of long-term care, the sale of the replacement policy must comply with all of the requirements of §3.3830. Additionally, if the policy being replaced is a life insurance policy, the insurer must comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), and Chapter 3, Subchapter NN (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the Department pursuant to the Insurance Code Chapter 1114. Further, if a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer must comply with §3.3830, Chapter 3, Subchapter NN, and the Insurance Code Chapter 1114.

§3.3837. Reporting Requirements. Adopted §3.3837(a) states that the purpose of §3.3837 is to specify the requirements for insurers to report information to the Commissioner on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses. Section 3.3837(a)(1)(A) specifies existing insurer requirements relating to agent records. Section 3.3837(a)(1)(B) re-adopts the provision in §3.3837(a)(2) (as it existed prior to this adoption). It provides that "Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance." Adopted new §3.3837(a)(2) addresses each insurer's reporting requirements for the 10 percent of its agents with the greatest percentages of policy or certificate lapses and replacements during the preceding calendar year. For these agents, each insurer is required to report by June 30 of each year the information indicated in the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form on the listing of the 10 percent of agents data as specified in adopted §3.3837(a)(2). Each insurer is required to submit the information electronically in a format prescribed by the department on the department's website. Adopted §3.3837(a)(3) addresses each insurer's reporting requirements for the number of lapsed long-term care policies. Each insurer is required to report by June 30 of each year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in adopted §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website. Adopted §3.3837(a)(4) addresses each insurer's reporting requirements for replacement of long-term care policies. Each insurer is required to report by June 30 of each year the number of replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

Adopted §3.3837(b) addresses insurer reporting requirements relating to rescissions. The section requires the use of Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies specified in §3.3837(b) in lieu of existing form LTC RESCIND that is currently adopted by reference in §3.3848. The existing form is included in §3.3837(b) with a new form number but without changes to the form requirements. The adopted amendments to §3.3837(b) clarify that each insurer must report to the Commissioner, by no later than June 30 annually for the preceding calendar year, all rescissions of long-term care insurance policies or certificates except those rescissions voluntarily effectuated by an insured. The new Form Number LHL563(LTC), consistent with existing form LTC RESCIND, requires each insurer to report for each rescission the policy form number, the policy and certificate number, the name of the insured, the date of the policy issuance, the date or dates that a claim or claims were submitted, the date of rescission, and a detailed reason for each rescission. Under the adopted amendments to §3.3837(b), the required information in new Form Number LHL563(LTC) must be submitted electronically in a format prescribed by the Department. The adopted amendments to §3.3837(b), including the new Form Number LHL563(LTC), result in all of the insurer reporting requirements in the subchapter being located in §3.3837. It is anticipated that this single-section location will result in more efficient organization and greater clarity that will facilitate implementation, compliance, and enforcement of the rules.

Section 3.3837 addresses insurer reporting requirements for claims denied by class of business. Adopted new §3.3837(c)(1) defines the terms "claim" and "denied." The adopted amendments to subsection (c) require insurers to use adopted new Form Number LHL564(LTC) Long-Term Care Claim Denials Reporting Form, which is specified in §3.3837(c)(2), to comply with the reporting requirements in subsection (c)(2). Under the adopted amendments, each insurer is required to report 11 data elements for both state data and nationwide data for all long-term care insurance claim denials under in-force long-term care insurance policies, including total number of long-term care claims reported, total number of long-term care claims denied/not paid, number of claims not paid due to preexisting condition exclusion, and number of claims not paid due to waiting period not being met. The adopted amendments to §3.3837(c)(2) require the data in Form Number LHL564(LTC) to be submitted electronically in a format prescribed on the Department's website.

Adopted new §3.3837(d) addresses insurer reporting requirements for the long-term care partnership program. It applies to all insurers that market long-term care insurance in Texas. The new rule requires that each insurer report to the Department by June 30 of each year the information required in §32.107 of the Human Resources Code. Each insurer must specify the number of approved partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year. The information required in subsection (d) must be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in §3.3837(e). The required information includes reporting for two long-term care partnership policy types: comprehensive (institutional and community care) and nursing home (institutional only). Each insurer must submit the required information electronically in a format prescribed on the Department's website. SB 22 enacted new §32.107 of the Human Resources Code that requires the Texas

Health and Human Services Commission (HHSC) to report this information in a biennial report to the Legislature by not later than September 30 of each even-numbered year. The purpose of the report is to provide information to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. The Department will report this data to the HHSC for use in fulfilling the HHSC requirements under §32.107 of the Human Resources Code.

Adopted new §3.3837(e) addresses insurer reporting requirements for both partnership and non-partnership plans. It applies to all insurers that market long-term care insurance in Texas. Under §3.3837(e), all such insurers must report to the Department by June 30 of each year the number of non-partnership plans sold in the state during the preceding calendar year and the average age of individuals purchasing the non-partnership plans during the preceding calendar year. The information required in adopted new subsection (e) must be reported in accordance with Form Number LHL565(LTC) as specified in §3.3837(e). The required information includes reporting for four long-term care non-partnership policy types: comprehensive (institutional and community care); nursing home (institutional only); home health care (community-based services); and riders (attached to life policies or annuity contracts.) Each insurer must submit the required information electronically in a format prescribed on the Department's website. New §3.3837(e) implements the provision of SB 22, codified as Human Resources Code §32.107. Section 32.107 requires that not later than September 30 of each even-numbered year the Texas Health and Human Services Commission (HHSC) shall submit a report to the Legislature on the progress of the partnership program for the preceding biennium. Section 32.107 also provides that the HHSC may request information from the Texas Department of Insurance as necessary to prepare the biennial report. In order to provide a meaningful, comprehensive report on the progress of the partnership program to the Legislature, insurers must report the non-partnership data specified in adopted new §3.3837(e) as well as the partnership data specified in adopted new §3.3837(d).

Adopted new §3.3837(f) provides new suitability reporting requirements for all insurers that market long-term care insurance policies in Texas. Insurers are required to provide suitability data on non-partnership and partnership policies sold in Texas in accordance with the requirements indicated in new Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in §3.3837(f)(1). The data is required to be reported to the Commissioner by no later than June 30 annually for the preceding calendar year. Under the new requirements, insurers are required to report suitability data for long-term care partnership comprehensive (institutional and community care) and nursing home (institutional only) policies that includes total number of applications received, total number of applicants who declined to provide the personal worksheet information, total number of applicants who did not meet the suitability standards, and total number of applicants who chose to confirm after receiving a suitability letter. New §3.3837(f) requires insurers to report the same suitability data for long-term care non-partnership comprehensive, nursing home, and home health care policies, and riders attached to life policies and annuity contracts. The reporting requirements require insurers to submit the data electronically in a format prescribed on the Department's website. New §3.3837(f) requirements for reporting suitability data provide the Department with a mechanism for monitoring the marketing practices of those insurers that market partnership policies as well as those insurers that market non-partnership policies. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. Adopted new §3.3837(f)(2)(A) clarifies that the subsection (f) suitability reporting requirements apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted new §3.3837(f)(2)(B) exempts from the subsection (f) suitability reporting requirements life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Adopted new §3.3837(g) contains the requirement in existing §3.3837(a)(5) that requires insurers to file an annual rate filing as required under the Insurance Code §1651.053(c) (former Insurance Code Article 3.70-12 §4(b)) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the Commissioner relating to loss ratios. The requirement applies to both partnership and non-partnership long-term care policies. Adopted §3.3837(g) clarifies that the demonstration of compliance with applicable loss ratio standards that is in the current rule (existing §3.3837(a)(5) which is now included in §3.3837(g)) is in addition to any demonstration required under §3.3831(c)(2)(B) - (D) and that compliance with the statutory requirement includes providing the following information by calendar duration and separately by form number: (i) calendar duration; (ii) first year issued; (iii) actual earned premium by duration; (iv) actual incurred claims; (v) actual calendar duration loss ratio; (vi) anticipated calendar duration loss ratio; and (vii) number of insured lives. This also applies to partnership and non-partnership long-term care policies. The requirements in §3.3837(g) clarify the information that an insurer must provide in order to demonstrate compliance with the Insurance Code §1651.053(c)(1).

§3.3838. Filing Requirements for Advertising. The adopted amendments to §3.3838(1) refine the requirements for the advertising of partnership and non-partnership long-term care insurance. Under the amendments, it is not necessary for insurers to file institutional advertisements (as that term is defined in 28 TAC §21.102 (relating to Scope)) if the advertisement only references long-term care insurance as a line of coverage. However, institutional advertisements that provide details regarding the insurer's long-term care insurance products that go beyond merely identifying long-term care insurance as a line of coverage that is available from the insurer continue to be subject to prior approval by the Commissioner and subject to the requirements in existing §3.3838. There are no changes to existing §3.3838(2) and (3).

§3.3839. Standards for Marketing. Section 3.3839 specifies the marketing procedures that must be established and implemented by each insurer, health care service plan, or other entity marketing, either directly or through its agents, partnership or non-partnership long-term care insurance in this state. Adopted new §3.3839(a)(8), (9) and (10) mandate three new requirements: (i) each insurer or other entity marketing long-term care insurance in this state must, at the time of solicitation, provide written notice to the prospective policyholder that a senior insurance counseling program is available; (ii) each insurer or other entity must provide to the applicant at the time of applica-

tion an explanation of the contingent nonforfeiture benefit upon lapse specified in §3.3844(g)(1), and if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided to policies with fixed or limited premium payment periods provided in §3.3844(g)(2); and (iii) each insurer or other entity must provide to the applicant, at the time of application, copies of the Long-Term Care Personal Worksheet as specified in §3.3829(b)(8)(H) and the Long-Term Care Potential Rate Increase Disclosure Form as specified in §3.3829(b)(8)(I). The adopted amendments to §3.3839 also provide that the required notices in existing §3.3839(b)(1) and (2), relating to the existence or non-existence of inflation protection provisions in each policyholder's policy, are also marketing procedure requirements, along with the other marketing procedure requirements specified in §3.3839(a), that are subject to Department audit to verify compliance. These current notices, which are redesignated as §3.3839(a)(11)(A) and (B), respectively, must be provided to each policyholder who purchases a policy that contains inflation protection provisions and to each policyholder who purchases a policy that does not contain inflation protection provisions.

Existing §3.3839(b), which is redesignated as §3.3839(a)(11), specifies the requirements for providing the required notices to policyholders. No changes are adopted to the existing required notices or to the existing requirements for providing the notice to policyholders.

§3.3842. Appropriateness of Recommended Purchase. Adopted new §3.3842(b) - (l) add several new requirements to existing §3.3842. These requirements concern suitability standards of the insurer, health service plan, or other entity (issuer) marketing long-term care insurance. These requirements apply to both partnership and non-partnership long-term care insurance coverage. These requirements are in addition to the requirement in existing §3.3842, which requires the company and the agent in recommending the purchase or replacement of any long-term care insurance policy or certificate, to make reasonable efforts to determine the appropriateness of the recommended purchase or replacement. This existing requirement, which is re-designated as §3.3842(a), constitutes the entirety of existing §3.3842. Adopted new §3.3842(b)(1) - (3) requires each issuer to (1) develop and use suitability standards to determine whether the purchase or replacement of a long-term care policy is appropriate to the needs of the applicant, (2) train its agents in the use of the issuer's suitability standards, and (3) maintain a copy of its suitability standards that is available to the Commissioner for inspection upon request.

Adopted new §3.3842(c)(1) - (3) requires that the agent and issuer develop suitability procedures to determine whether the applicant meets the issuer's standards. In developing these procedures, the agent and issuer must consider the following factors: (1) the applicant's ability to pay for the proposed coverage and other pertinent financial information; (2) the applicant's goals and needs with respect to long-term care; and (3) the values, benefits, and costs of the applicant's existing insurance as compared to the values, benefits, and costs of the recommended purchase or replacement.

Adopted new §3.3842(d) requires the issuer or, if an agent is involved, the agent to make reasonable efforts to obtain the information required in adopted new §3.3842(c) and that the efforts shall include presentation to the applicant of new Form Number LHL560(LTC) Long-Term Insurance Care Personal Worksheet that is specified in §3.3829(b)(8)(H). Under new §3.3842(d), the issuer may request the applicant to provide additional information on the Personal Worksheet to comply with the issuer's suitability standards. However, if the issuer requests such additional information, the issuer must comply with the following requirements that are specified in new §3.3842(d)(1) - (3): (i) a copy of the issuer's Personal Worksheet that includes the additional information must be filed with the Department for approval at least 60 days prior to use; (ii) the filing is subject to the requirements and procedures in Chapter 3, Subchapter A; and (iii) the filing should be submitted to the Filings Intake Division of the Department.

Adopted new §3.3842(e) requires the completed Long-Term Care Personal Worksheet to be returned to the issuer prior to the issuer's consideration of the applicant for coverage; however, this is not required for sales of employer group long-term care insurance. Adopted new §3.3842(f) prohibits the sale or dissemination of information obtained through completion of the Long-Term Care Personal Worksheet. Adopted new §3.3842(g) requires the issuer to use suitability standards that it has developed pursuant to §3.3842 in determining the appropriateness of issuing long-term care insurance to an applicant. Adopted new §3.3842(h) requires agents to use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

Adopted new §3.3842(i) requires issuers to provide to the applicant at the same time the Personal Worksheet is provided the new disclosure Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance. This form provides important information to the consumer concerning the general functions of a long-term care insurance policy, Medicare and Medicaid as those programs relate to long-term care insurance, the availability of a Shopper's Guide for Long-Term Care, the availability of a senior health insurance counseling program, and general information concerning long-term care facilities. This disclosure form will help the applicant decide whether or not it is prudent to purchase a long-term care policy. Additionally, adopted new §3.3842(i)(1) - (6) specify the requirements and procedures that apply to adopted new Form Number LHL567(LTC), including text size and content, recommended format, and filing and approval procedures as applicable. A representation of new Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is specified in §3.3842(i)(7).

Adopted new §3.3842(j) addresses actions to be taken if the issuer determines that the applicant does not meet its financial suitability standards or if the applicant has declined to provide the requested information. If either of these events occur, the adopted subsection provides that the insurer may either reject the application or, if the issuer does not opt to reject the application, the issuer is required to send the applicant a letter in accordance with or similar to new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of new §3.3842(j), the Suitability Letter must be in accordance with or similar to new Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. The Suitability Letter must comply with the requirements and procedures specified in §3.3842(j)(1) - (4) which are as follows: (i) the Suitability Letter must use the text specified adopted §3.3842(j) or be similar to the text in such figure, (ii) the text must be in at least 12-point type, and (iii) the *Instructions to Company* and form number are not to be included in the letter sent to the applicant. The letter will inform an applicant that the issuer has reviewed the financial information provided by the applicant on the personal worksheet

and has determined that the applicant is not financially suitable to purchase long-term care insurance and that review of the application has been suspended or that the applicant has not provided any or has provided insufficient financial information for the issuer to make a determination as to the applicant's suitability to purchase a long-term care policy and that review of the application has been suspended. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file.

In accordance with the definition of "long-term care insurance" in §3.3804(20), adopted §3.3842(k) provides that §3.3842 and the delivery requirements for the shopper's guide in §3.3840 apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Existing §3.3840 requires that a long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners be provided to all prospective applicants of a long-term care insurance policy or certificate, as follows: (1) In the case of agent solicitation, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form; and (2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form. Adopted §3.3842(l) exempts certain life insurance policies from the §3.3842 requirements and the delivery requirements for the shopper's guide in §3.3840. In accordance with the definition of "long-term care insurance" in §3.3804(20), adopted §3.3842(l) exempts from the requirement of delivery of the shopper's guide (booklet) life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits. Existing §3.3844(a) - (g) specifies several requirements pertaining to nonforfeiture and contingent nonforfeiture benefits in long-term care policies and certificates. No changes are adopted to existing §3.3844 (a), (b), (d), or (f). An adopted amendment to §3.3844(c)(3) corrects the erroneous word "shorten" to read "shortened." Existing §3.3844(g)(1) is unchanged in this adoption. However, a new §3.3844(g)(2) is adopted.

Adopted new §3.3844(g)(2) provides that in addition to the provision in §3.3844(g)(1) for the triggering of contingent nonforfeiture benefits on lapse, such contingent nonforfeiture benefits shall be triggered for policies or certificates with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium specified in the table in §3.3844(g)(2). This will be based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio specified in adopted §3.3844(g)(4)(B) is 40 percent or more. Adopted §3.3844(g)(2) also provides that unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. A contingent nonforfeiture benefit is a type of nonforfeiture benefit that becomes available to the policyholder when the contingency of a substantial rate increase occurs. The triggers for a substantial rate increase are contained in the tables in §3.3844(g)(1) and §3.3844(g)(2) and are expressed as a function of the issue age of the insured and the percent increase over initial premium that the insured paid. The revised contingent nonforfeiture benefit on lapse provision for policies with limited premium payment periods require insurers to include these protections in their policies. The contingent nonforfeiture benefit on lapse provisions provide a safety net to policyholders who are forced to allow their long-term care policies to lapse because they are unable to pay a substantial rate increase.

Adopted new §3.3844(g)(4)(A) and (B) require the insurer to make certain offers to the insured for a policy or certificate with a fixed or limited premium payment period when there is a substantial rate increase and the policy has lapsed within 120 days of the due date of the premium that was substantially increased. The insurer must offer to the policyholder the option to either: (i) reduce the policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; or (ii) convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period.

Adopted new §3.3844(g)(4)(C) requires the insurer to notify the policyholder that a lapse or default at any time during the 120-day period shall be deemed to be the insured's election of the offer to convert as set forth in §3.3844(g)(4)(B).

Adopted new §3.3844(e) limit the application of subsection (e) to contingent nonforfeiture benefits upon lapse in the event of a default in payment of premiums in accordance with §3.3844(g)(1). Section 3.3844(e) also provides that §3.3844(e) does not apply to contingent nonforfeiture benefits upon lapse in accordance with §3.3844(g)(2). Section 3.3844(g)(2) provides that a contingent nonforfeiture benefit on lapse is also triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium as set forth in the table Triggers for a Substantial Premium Increase in §3.3844(g)(2) based on certain specified factors. The addition of this revised contingent nonforfeiture benefit on lapse provision will provide consumers with greater protections if their policies lapse. This provision ensures that, in the event that an insured is unable to pay the substantial rate increase and is therefore forced to let their policy lapse, the insured will receive at least some benefits for the premiums he or she has paid in over the years. Adopted new §3.3844(h) addresses the applicability of §3.3844. Under adopted §3.3844(h)(1), the requirements in §3.3844 apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Under adopted §3.3844(h)(2), the requirements in §3.3844 do not apply to life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and provide the option of a lump-sum payment for those benefits and where neither the

benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders. Adopted §3.3848 specifies several regulatory requirements pertaining to limited premium payment options that apply to both partnership and non-partnership long-term care policies. These requirements govern noncancellation, guaranteed renewability, and return of premium practices for long-term care plans with limited premium payment options. Adopted new §3.3848(a) specifies that long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years. Under adopted new §3.3848(a), limited premium payment policies, certificates, and riders must comply with the rules in 28 TAC Chapter 3, Subchapter A and Subchapter Y and the additional requirements specified in §3.3848(b). Also, any policy, certificate or rider that contains a paid-up option at a specified age and becomes paid up in 10 years or less is subject to the §3.3848 requirements. Adopted new §3.3848(a) also provides that carriers are not prohibited from offering premium payment duration options in excess of 10 years, and if offered, the options are not subject to §3.3848.

Adopted new §3.3848(b)(1) requires a long-term care insurance policy or certificate with a limited premium payment option to accurately reflect a plan with a limited payment option. Adopted new §3.3848(b)(2) requires the provisions in long-term care policies, certificates, and riders with limited premium payment options to be at least as favorable as the requirements and provisions specified in §3.3848. Adopted §3.3848(b)(3) - (5) specify the requirements for three types of limited premium payment policies, certificates, and riders, including single-premium payment option, one-to-four-year premium payment options, and five-to-ten year premium payment options. Single-premium payment option policies must be noncancellable and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(3) that states the premiums are paid by a single premium, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

One-to-four year premium payment option policies must be noncancellable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(4) that states the premiums are paid over a period of [n] (n may equal 1, 2, 3, or 4) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

Five-to-ten year premium payment option policies must be guaranteed renewable, and the renewability provision in the policy must conform with the provision specified in §3.3848(b)(5)(A) that states the premiums are paid over a period of [n] (n may equal 5, 6, 7, 8, 9, or 10) years, that the policy cannot be cancelled by the insurer, and that no changes can be made to the policy unless requested by the insured. The renewability provision must be either on the face page of a policy or certificate or may be added to the policy via an endorsement and change to the schedule page.

Additionally, for those policies, certificates, and riders with a five-to-ten year premium payment option, a provision must be included in the policy, certificate, or rider that provides for a return of premium upon cancellation, as provided in the Return of Premium Schedule in §3.3848(b)(5)(C)(ii) and must be accompanied by the disclosure notice specified in §3.3848(b)(5)(C)(i). The return of Premium Schedule chart in §3.3848(b)(5)(C)(ii) specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled and must comply with the requirements specified in §3.3848(b)(5)(C)(ii)(I) and (II), including text font size and format. Adopted §3.3848(b)(5)(D) and (E) provide a formula for using the Return of Premium chart to determine the total return of premium amount.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies. Adopted new §3.3849 specifies certification requirements for insurers that issue partnership and non-partnership policies to associations and marketing standards for associations, as defined in the Insurance Code §1251.052, that market partnership and non-partnership policies. Insurers that issue such policies to associations are required under §3.3849(a)(1) to file with the Department the partnership and/or non-partnership policy and certificate, a corresponding outline of coverage, and an annual certification of the association's compliance with marketing standards for partnership and/or non-partnership policies and certificates in accordance with the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F). A representation of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates is specified in adopted new §3.3849(e)(1)(F).

Adopted new §3.3849(a)(2) provides that no group long-term care partnership and/or non-partnership policy or certificate may be issued to an association unless the insurer files with the Department the information required in §3.3849(a)(1).

Adopted new §3.3849(e)(1)(A) - (D) specify the requirements and procedures that apply to Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in §3.3849(e)(1)(F), including text content, text font size, and recommended format. Adopted new §3.3849(e)(2) requires that insurers submit the initial certification to the Department between January 1, 2010 and January 31, 2010, for the calendar year 2009. Thereafter, they must submit the certification annually between January 1 and January 31 for the preceding calendar year.

Under adopted new §3.3849(e)(3), the certification form is an informational filing pursuant to §3.5(b)(1) and is subject to the requirements and procedures in Chapter 3, Subchapter A of Title 28 of the Texas Administrative Code. Adopted new §3.3849(e)(4) specifies where the annual completed certification form should be filed. The function of this subsection is to provide information to assist the Department in monitoring each association's compliance with the §3.3849 requirements, including an association's compliance with marketing standards for partnership and non-partnership policies and certificates in

accordance with the Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form. The monitoring will enable the Department to identify possible violations, including unfair marketing practices, in a timely manner so that the Department can take corrective action to protect association members. Additionally, the certification form in §3.3849(e)(1)(F) will ensure timely and efficient filing of the required certification information with the Department.

Adopted new §3.3849(b) requires advertisements for long-term care partnership and non-partnership insurance to be filed with the Department in accordance with §3.3838(1) (relating to Filing Requirements for Advertising). The function of §3.3849(b) is to enable the Department to timely identify and prevent unfair or deceptive advertising to association members who are considering applying for long-term care insurance coverage. This will help to ensure that association members are protected from unscrupulous and dishonest sales and enrollment practices.

Adopted §3.3849(c)(1) requires an association to disclose in any long-term care partnership and/or non-partnership insurance solicitation to its members: (i) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (ii) a brief description of the process under which the policies and the insurer issuing the policies were selected. Under §3.3849(c)(2), an association is required to disclose to its members the fact of any interlocking directorates or trustee arrangements between the association and the insurer. The function of these new requirements is to make consumers aware of factors, such as the financial arrangements between the insurer and the association and the extent of the insurer selection process, that will enable them to more effectively evaluate the pros and cons of the long-term care insurance solicitation. Also, the function of these requirements is to provide information to more consumers to enable them to more readily identify possible bias or deception in the marketing or solicitation of long-term care products by the association. These types of information will enable association members to be more than just pro forma participants in the purchase of their long-term care insurance if they so choose.

Adopted new §3.3849(d) requires an association's board of directors to review and approve the insurance policies and compensation arrangements the association has with the insurer. This requirement will enable the association's board of directors to examine and evaluate the long-term care benefits being purchased by the association's members and the financial arrangements between the insurer and the association to ensure that they are in the best interest of the members of the association.

§3.3860. Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts That Provide Long-Term Care Benefits. Adopted new §3.3860 sets forth the delivery and content requirements for the policy summary for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. The adopted requirements do not apply to any long-term care partnership policy. Adopted §3.3860(a) specifies that at the time of delivery of a life insurance policy or annuity contract that provides long-term care benefits by rider the insurer shall also deliver a policy summary. Adopted §3.3860(a) also specifies requirements for policy summary delivery for direct response solicitations. Adopted §3.3860(a)(1) - (5) specify the policy summary content requirements: (1) an explanation of how the benefits interact with other components of the policy; (2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefit; (3) any exclusions, reductions, and limitations on benefits; (4) a statement that the long-term care inflation protection option required by §3.3820 (relating to Requirement to Offer Inflation Protection) and the long-term care inflation protection provisions required for partnership policies by §3.3872 (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) are not available under this policy; and (5) if applicable to the policy type, a disclosure of the effects of exercising other rights under the policy; a disclosure of guarantees related to the cost of insurance charges, and a disclosure of current and projected lifetime benefits. Adopted §3.3860(b) provides that the provisions of the policy summary may be incorporated into a basic life insurance illustration that is required to be delivered in accordance with 28 TAC Chapter 21 Subchapter N (relating to Life Insurance Illustrations). Adopted §3.3860(c) specifies that any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit by rider, is in benefit payment status, a monthly report must be provided to the policyholder. Additionally, adopted §3.3860(c) specifies the information the monthly report is required to contain. Adopted new §3.3860(d) requires that the statement required in §3.3860(a)(4) applies to: (i) riders for group and individual annuities and life insurance policies that provide long-term care insurance and (ii) life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits, and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care; and (2) Adopted §3.3860(a)(4) specifies one of the requirements that must be included in the policy summary for a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider. It requires that a statement be included in the policy summary that any long-term care inflation protection option required by §3.3820 of this subchapter (relating to Requirement to Offer Inflation Protection) and §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available under this policy. Adopted §3.3860 will function to provide important information to the consumer to assist in determining whether to purchase a long-term care policy that is funded by a life insurance policy.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies. Adopted new §3.3870 applies only to long-term care partnership policies and specifies the requirements for the exchange of an existing long-term care policy for a new long-term care partnership policy. Adopted new §3.3870(a) addresses requirements for notification to policyholders eligible for exchange and the requirements for the offer of exchange. Adopted new §3.3870(a) extends the requirement for insurers to implement an exchange program to 18 months from the date the insurer initiates its partnership program and limits the offer to exchange under a policy or certificate to a policy or certificate of the type certified by the insurer. This will provide each insurer with an 18-month time period from the date that the insurer initiates it partnership program in which to make the required offer of exchange. Additionally, the offer is limited to insureds under a policy of the type certified by the insurer (e.g., if an insurer certifies an individual policy for partnership, certificate holders under a group policy are not required to receive an offer

of exchange for the individual partnership policy. The function of the 18-month time frame is to allow each insurer sufficient time to take the necessary steps to have the partnership policies on the market and available to insureds who have already purchased non-partnership policies.

Adopted new §3.3870(b) specifies the methods by which insurers may make the new coverage available, including: by adding a rider or endorsement to the existing policy or by exchanging the existing policy or certificate for a new partnership policy or certificate. Adopted new §3.3870(b)(2)(A) specifies the conditions for exchange for new coverage that has an actuarial value of benefits equal to or lesser than the actuarial value of the benefits of the existing coverage. Adopted new §3.3870(b)(2)(B) specifies the conditions for exchange for new coverage that has an actuarial value of benefits exceeding the benefits of the existing coverage. Adopted §3.3870(b)(2)(C) permits insurers to develop an alternative exchange methodology or program that may differ from the procedures and requirements specified in §3.3870(b)(2)(A) and (B). Under adopted §3.3870(b)(2)(C), an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the Department and approved by the Commissioner in accordance with the requirements and procedures set forth in 28 TAC Chapter 3, Subchapter A.

Adopted new §3.3870(c) addresses the general requirements for the exchange of an existing long-term care policy or certificate for a partnership policy or certificate. Adopted §3.3870(c)(1) - (5) specify the following requirements: (1) All offers of policy exchanges must be made on a nondiscriminatory basis; (2) An exchange offer must be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires; (3) All rates for exchanges must be in accordance with §3.3831 (relating to Standards and Rates); exchange policies may be underwritten and the premium may be increased in accordance with §3.3831; (4) The new coverage offered must be on a currently approved form; (5) In the event of an exchange, the insured shall not lose any rights, benefits, or built-up value under the original policy.

Adopted new §3.3870(d) provides that policies issued pursuant to this section shall be considered exchanges and not replacements. Adopted new §3.3870(e) requires an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. The insurer must report the information on Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form in accordance with the procedures and requirements specified in §3.3837(a)(4).

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies. Adopted new §3.3871 applies only to newly issued long-term care partnership policies and specifies the standards and reporting requirements for approved long-term care partnership policies. In addition to the required filing and approval pursuant to §3.3873, any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the requirements specified in §3.3871(a)(1)(A) - (D): (i) the insured individual must be a resident of Texas when coverage first became effective under the policy, and if the policy or certificate is later exchanged for a different long-term care policy or certificate the individual was a resident of Texas when the coverage under the first policy became effective; (ii) a partnership policy must be a tax qualified policy under the provisions of §3.3847 (relating to Qualified Long-Term Care Insurance Contracts: Prohibited Representations); (iii) the policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's attained age; and (iv) the effective date of the newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed; the insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer.

A policy or certificate represented or marketed as a long-term care partnership policy or certificate must be accompanied by a disclosure notice (a representation of which is specified in §3.3871(a)(2)(B)(vii)) that explains the benefits associated with the policy or certificate in accordance with the requirements in §3.3871(a)(2)(A) and (B). The required disclosure notice, titled "Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates," provides essential information to the insured relating to certain disclosures, including: (i) the policy purchased qualifies for the Texas partnership program; (ii) the partnership policy may protect the insured's assets through "asset disregard" under the Texas Medicaid program; (iii) the meaning of "asset disregard" and the fact that the purchase of a partnership policy does not guarantee the ability to disregard assets and does not automatically qualify the insured for Medicaid; (iv) the long-term care policy purchased confers partnership status as of the effective of the policy; (v) what could disqualify one's policy status as a partnership policy; and (vi) how the insured can obtain additional information on the partnership policy program. The notice, which is approximately one and one-half pages long, must be in at least 12-point type and must follow the order of the information presented in §3.3871(a)(2)(B)(vii). The text in the notice is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the Commissioner in accordance with the procedures in §3.3871(a)(2)(B)(iii) and (vi). The function of the disclosure notice is to ensure that individuals who purchase partnership policies have information in a separate document that accompanies the partnership policy that explains the benefits of the partnership program. Additionally, this notice will also be helpful in notifying family members or others who are administering the estate of the insured of the partnership status of the policy and of the estate recovery exemptions available for benefits paid under a partnership policy.

Adopted §3.3871(a)(2)(B)(viii) requires insurers to furnish any policyholder that exchanges their policy for a partnership policy with the required Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates that is specified in §3.3871(a)(2)(B)(vii). Adopted new §3.3871(a)(2)(B)(ix) requires that when an insurer is made aware that a policyholder has initiated an action that will result in the loss of partnership status, the insurer must advise the policyholder in writing of how to retain the partnership status if possible. Adopted new §3.3871(a)(2)(B)(x) requires that when a partnership plan loses partnership status, the insurer must explain in writing to the policyholders the reason for the loss of status

Adopted new §3.3871(b) specifies new reporting requirements for insurers that issue partnership policies. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI) and (v)), all issuers of partnership policies or certificates must provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. As provided under adopted §3.3871(b)(1) - (3), such information shall include but not be limited to the following: (i) notification of when insurance benefits provided under a partnership policy have been paid and the amount of such benefits, (ii) notification regarding when such policies terminate, and (iii) any other information the Secretary determines is appropriate. Adopted new §3.3871(b) implements the provision of SB 22, codified as Insurance Code §1651.104. Section 1651.104 requires that a partnership policy be consistent with the provisions governing the expansion of a state long-term care partnership program established under the DRA. Section 1917(b)(1)(C)(iii)(VI) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VI)) includes the requirements that are adopted in §3.3871(b). Adopted new §3.3871(b) provides Department rules that are consistent with the DRA reporting requirements for insurers that issue long-term care partnership policies. The information that insurers report to the Secretary of Health and Human Services will enable the Secretary to monitor the partnership program in Texas in accordance with the insurer reporting requirements established under the DRA.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates. Adopted new §3.3872 applies only to long-term care partnership policies and specifies the inflation protection requirements for long-term care partnership policies and certificates. Adopted new §3.3872(a)(1) specifies that for a person who is less than 61 years of age as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains age 61. Adopted new §3.3872(a)(1)(A) requires the insurer to offer to each applicant at the time of purchase the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage; the inflation protection is required to automatically increase benefits each year on a compounded basis. Adopted new §3.3872(a)(1)(B) specifies that if the applicant declines the offer of not less than 5.0 percent compound annual inflation protection, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U). Adopted new §3.3872(a)(1)(C) specifies that a person who is less than 61 years of age who has purchased a long-term care partnership policy or certificate with the required compound inflation protection may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(a)(2). Adopted new §3.3872(a)(2) specifies that for a person who is between 61 and 76 years old, the policy must provide some acceptable level of inflation protection until the person attains 76 years of age. Adopted new §3.3872(a)(2)(A) specifies that regardless of the insured's health status the insurer must offer inflation protection and the insured must accept and retain inflation protection until the insured attains age 76 or goes on claim status. Adopted new §3.3872(a)(2)(A) - (D) specify that acceptable inflation protection includes: (i) regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first; (ii) acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium; (iii) the Inflation protection may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U); and (iv) a person who is less than 76 years of age who has purchased a long-term care partnership policy or certificate with the required inflation protection may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in §3.3872(3). Adopted new §3.3872(a)(3) specifies that for a person who is 76 years old, inflation protection may be provided but is not required. Section 3.3872(a)(3) also clarifies that although inflation protection is not required for any applicant for a partnership policy who has attained the age of 76, the offer of the long-term care inflation protection option in §3.3820 is still required for any such applicants.

Adopted new §3.3872(a)(4) specifies that an option to purchase inflation protection in the future does not constitute compliance with the requirements in §3.3872(1) and (2).

Adopted new §3.3872(b) clarifies the types of policies for which inflation protection is not available. Under §3.3872(b), the §3.3872 inflation protection provisions are not available (1) under riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) under life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies. Adopted new §3.3873 applies only to long-term care partnership policies and specifies the filing and prior approval requirements that apply to any partnership policy, certificate, or endorsement that is to be delivered or issued for delivery in this state. Adopted new §3.3873(a)(1) requires that each partnership policy, certificate, or endorsement be filed with the Department and approved in accordance the procedures in Chapter 3, Subchapter A and §3.3873(b) and (c) as applicable. Adopted new §3.3873(a)(2) requires that each partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form specified in §3.3873(a)(2)(F). Adopted new §3.3873(a)(2)(A) - (F) set forth the requirements and procedures that apply to Form Number LHL570(LTC), including text content and font size, order of information presented, format requirements, and filing and approval requirements if applicable. The adopted certification form specifies the elements of information that are required to be provided by each insurer for each partnership policy, certificate, or endorsement that is filed by the insurer for approval by the Commissioner for use under the Qualified Partnership Program. Pursuant to §1917(b)(5)(B)(iii) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, when implementing a qualified state long-term care insurance partner-

ship program, is authorized to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) and principally include certain specific provisions of the 2000 NAIC Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act. The certification form to be filed by the insurer requests information relating to: (i) in Section I, general information relating to the insurer's name and address, a contact person for information relating to the filing, the policy form number(s) or other identifying information; for a policy form not previously approved, copies of the policy forms including any riders or endorsements must be included; and for a policy form previously approved, only identifying policy information must be included; (ii) in Section II, the insurer's response regarding whether the specified requirements of the Model Regulations and Model Act are met with respect to all policies and certificates that are intended to be included under the Qualified Partnership Program; and (iii) in Section III, the insurer's certification to the Commissioner that all of the attached or identified policy forms, riders and endorsements meet all of the requirements of the Model Regulations and Model Act that are specified in the Federal Deficit Reduction Act of 2005 and that all of the answers, accompanying information, and other information contained in the certification form are true, correct and complete.

Adopted new §3.3873(b) sets forth the requirements and procedures for the filing of a policy, certificate, or endorsement that has not been previously approved by the Commissioner. Any such policy, certificate, or endorsement that is offered for sale in Texas as a partnership policy, must comply with the adopted requirements in §3.3873(b)(1) - (4), including (i) the policy, certificate, or endorsement must be filed with the Department and approved by the Commissioner, and Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form must be submitted for each policy, certificate, or endorsement form submitted for partnership approval; (ii) the policy, certificate, or endorsement form must be in at least 10 point type; (iii) the policy form filing must be filed at least 60 days prior to use and is subject to the requirements and procedures in Chapter 3, Subchapter A; and (iv) and any policy form filing should be filed with the Filings Intake Division of the Texas Department of Insurance.

Adopted new §3.3873(c) specifies the requirements and procedures for insurers requesting to use a previously approved non-partnership long-term policy as a long-term care partnership policy. Prior to offering the policy for sale in Texas as a partnership policy, the policy, certificate, or endorsement must comply with the adopted requirements in §3.3873(c)(1) - (6), including: (i) the insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form and a copy of any endorsement that is needed to comply with the partnership policy requirements; (ii) the policy form numbers or other identifying information must be included on Form Number LHL570(LTC); (iii) the filing must be approved by the Commissioner prior to the use of the form as a partnership policy; (iv) a previously approved policy or certificate does not have to be included in the filing; (v) the filing made must be made at least 60 days prior to use and is subject to the procedures in Chapter 3, Subchapter A; and (vi) the filing should be submitted to the Filings Intake Division of the Texas Department of Insurance.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates. Adopted new §3.3874 applies only to long-term care partnership policies and specifies insurer requirements for reporting information to the Department on agents that market long-term care partnership plans. Adopted new §3.3874(a)(1) - (3) specify training verification and certification requirements for insurers with agents who market partnership plans. These requirements are: (i) obtaining of verification that an agent has received the training specified in §19.1022 of Chapter 19 of Title 28 of the Texas Administrative Code (relating to Long-Term Care Partnership Certification Course); (ii) insurer certification to the Commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection; and (iii) insurer's maintenance of verification records for at least four years; records are subject to review by the Department or its designee at any time. The initial certification (for the period from the effective date of the rules to June 1, 2009) must be submitted on Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form specified in §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form specified in §3.3874(b)(6)(B).

Adopted new §3.3874(b) specifies the requirements and procedures that apply to Form Number LHL571(LTC) and Form Number LHL572(LTC), including text content, text font size, recommended format, and filing and approval requirements and procedures as applicable.

Adopted new §3.3874(c)(1) - (3) specify the filing requirements for the agent training certification by each insurer. An insurer offering partnership policies or certificates must submit: (i) Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form for the initial certification, and (ii) Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form for each subsequent annual certification. The initial certification form, Form Number LHL571(LTC), is to be used for certification by the insurer for the initial certification period (from the effective date of the rules to June 1, 2009). This form will be used by the insurer to certify that each individual who is currently selling partnership policies has completed training and demonstrated evidence of understanding long-term care partnership policies. Insurers will file the annual certification Form Number LHL572(LTC) annually with the Department beginning in January 2010 to certify that each individual who currently sells partnership policies for the insurer has completed the required training before the agent sells or solicits the insurer's partnership products.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Exemptions from Certain Requirements

§3.3820. Requirement to Offer Inflation Protection

§3.3837(f). Suitability Data Reporting Requirements

§3.3840. Requirements to Deliver Shopper's Guide

§3.3842. Appropriateness of Recommended Purchase

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits

Comment: Commenters assert that there are various consumer protection requirements in the proposed text that do not apply

to life policies that have acceleration riders and that exemptions from these requirements are necessary for consistency with the NAIC Model Regulations. According to the commenters, these sections are (i) §3.3820 (Requirement to Offer Inflation Protection), (ii) §3.3837(f) (Suitability Data Reporting Requirements), (iii) §3.3840 (Requirements to Deliver Shopper's Guide), (iv) §3.3842 (Appropriateness of Recommended Purchase), and (v) §3.3844 (Nonforfeiture and Contingent Nonforfeiture Benefits). The commenters point out that in the NAIC Model Regulations life insurance policies that have acceleration riders are exempt from these consumer protection requirements. The commenters further assert that under the NAIC Model Regulations the policy summary that is given to the policyholder at the time of policy delivery, in accordance with §3.3860, is in lieu of these consumer protection requirements. The commenters, therefore, request that the proposed text be modified to provide an exemption from the requirements of each of the specified sections for life policies that have acceleration riders.

Some commenters recommend that §3.3820 be modified to include the NAIC Long-Term Care Insurance Model Regulation exemption for inflation for life acceleration riders. The requested exemption reads: "The offer shall not be required of life insurance policies or riders containing accelerated long-term care benefits."

Some commenters recommend that §3.3837(f) be modified to include the NAIC Long-Term Care Insurance Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability reporting requirements in §24H of the NAIC Long-Term Care Insurance Model Regulations. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care."

Some commenters recommend that §3.3840 be modified to include the NAIC Long-Term Care Insurance Model Regulation §32B which exempts life insurance policies that accelerate benefits for long-term care from the requirement to deliver a Long-Term Care shopper's guide. The requested exemption reads: "Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under §3.3860."

Some commenters recommend that §3.3842 be modified to include the NAIC Model Regulation §24A which exempts life insurance policies that accelerate benefits for long-term care from the suitability requirements. The requested exemption reads: "This section shall not apply to life insurance policies that accelerate benefits for long-term care."

Some commenters recommend that §3.3844 be modified to include the NAIC Model Regulation §28A which exempts life insurance forms from the nonforfeiture and contingent nonforfeiture benefits requirements. The requested exemption reads: "This section does not apply to life insurance policies or riders containing accelerated long-term care benefits."

Agency Response: The Department agrees that certain life insurance policies that accelerate benefits for long-term care should be exempt from the requirements in §§3.3820, 3.3837, 3.3840, 3.3842, and 3.3844. The Department, however, does not agree with the commenter's recommended exemption language. The following discusses the Department's reasoning and the changes made to the proposed text in response to the comments.

Section 3.3820 Exemption. The commenter's recommended exemption language for §3.3820 is substantially similar to §13C of the NAIC Long-Term Care Insurance Model Regulations. However, the consumer protection provisions required by the DRA do not include §13 or §13C of the NAIC Long-Term Care Model Regulations. The Department's existing long-term care rules in §3.3820 that relate to the requirement to offer inflation protection, however, do include the inflation protection provisions of Model Regulation §13 except for the §13C exemption requested by the commenters. While the Department agrees that certain "life insurance policies or riders containing accelerated long-term care benefits" should be exempt from the §3.3820 requirement to offer inflation protection, it is not possible to add the requested exemption to §3.3820 because such a change is substantive. Section 3.3820 was not proposed for amendment in the proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635). Therefore, a change as requested by the commenters may not be made to existing §3.3820. In lieu of adding the requested exemption language to §3.3820, the Department is making (i) an addition to §3.3860 to address the requested exemption; and (ii) a clarification addition to the §3.3804(21) definition of "long-term care partnership insurance policy." As previously stated, §3.3820 addresses the requirement to offer inflation protection to all applicants for long-term care insurance. Proposed new §3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider. The definition in proposed §3.3804(21) defines a "long-term care partnership insurance policy" as a long-term care insurance policy that is established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code. Chapter 32, Subchapter C of the Human Resources Code addresses the establishment and operation of the Partnership for Long-Term Care Program in Texas. A life insurance policy or annuity contract that provides long-term care benefits by rider does not comply with the definition of "long-term care partnership insurance policy" in proposed §3.3804(21). A partnership policy must contain an inflation protection provision as required by §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)). The DRA inflation protection provision is implemented in new §3.3872 (relating to long-term care partnership policies and certificates). Section 1651.104 of the Insurance Code requires that a long-term care partnership policy that is funded by a life insurance policy be consistent with the provisions in §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements include the provisions in §6J and §6K of the NAIC Long-Term Care Model Act. Proposed §3.3860 is consistent with the §6J and §6K requirements. It is also consistent with the definition of "long-term care partnership insurance policy" in §3.3804(21).

Section 3.3860(a) specifies that a policy summary must be provided with a life insurance policy or annuity contract that provides long-term care benefits by rider. Section 3.3860(a)(4) requires that the policy summary for this type of policy contain a statement that provides that any long-term care inflation option required by §3.3820 and §3.3872 is not available under this policy.

Therefore, to address the commenter's recommendation relating to the §3.3820 exemption, the Department is adopting an addition to proposed new §3.3860. A new subsection (d) is added to adopted §3.3860 to read: "The statement required in subsection (a)(4) of this section applies to: (1) riders for group and individual annuities and life insurance policies that provide long-term care insurance; and (2) life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits, and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care." The provision exempts the life insurance policies, annuity contracts, and riders specified in adopted §3.3860(d)(1) and (2) from the §3.3820 requirement to offer inflation protection and further provides that §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available for such policies.

For purposes of clarity and consistency, the following provision is added to the adopted §3.3804(21) definition of "long-term care partnership insurance policy": "This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider." This addition simply clarifies the §3.3804(21) definition and is consistent with §3.3860(a)(4) and (d).

Sections 3.3837, 3.3840, 3.3842, and 3.3844 Exemptions. The commenter's recommended exemption language for §§3.3837, 3.3840, 3.3842, and 3.3844 is not consistent with the definition of "long-term care insurance" in §3.3804(20). Each of these recommended exemption provisions pertains to: (i) life insurance policies that accelerate benefits for long-term care; and/or (ii) life insurance policies or riders containing accelerated long-term care benefits. In the adopted text, however, it is necessary to more specifically identify the policies or riders subject to the exemptions. This is necessary for consistency with the definition of "long-term care insurance" in §3.3804(20).

The commenters request that life insurance policies or riders containing accelerated long-term care benefits be exempt from: (i) the §3.3837(f) suitability reporting requirements; the NAIC Long-Term Care Insurance Model Regulation §24A exempts such policies; (ii) the §3.3840 requirement of the delivery of the Long-Term Care shopper's guide; NAIC Model Regulation §32B exempts such policies and riders; (iii) the §3.3842 suitability requirements; NAIC Model Regulation §24A exempts such policies; and (iv) the §3.3844 nonforfeiture and contingent nonforfeiture benefits requirements; NAIC Model Regulation §28A exempts such life insurance forms. The definition of "long-term care insurance" in §3.3804(20) provides that "long-term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Therefore, these types of life insurance policies are not defined as "long-term care insurance" for purposes of §§3.3837, 3.3840, 3.3842, and 3.3844 and are properly exempt from the long-term care consumer protection requirements in those four sections. As a result, §§3.3837(f)(2)(B), 3.3842(l), and 3.3844(h)(2) as adopted contain exemption language that is consistent with the definition of "long-term care insurance" in §3.3804(20). Adopted §3.3842(l) also addresses the exemption from the §3.3840 requirement of delivery of the shopper's guide.

The definition of long-term care insurance in §3.3804(20) provides that riders for group and individual annuities and life insurance policies that provide long-term care insurance are long-term care insurance for purposes of the Subchapter Y rules, including §§3.3837, 3.3840, 3.3842, and 3.3844. Therefore, it is necessary that these types of policies be afforded the consumer protection requirements in the four sections. These types of riders cannot be subject to the requested exemption. Therefore, §§3.3837(f)(2)(A), 3.3842(k), and 3.3844(h)(1) as adopted provide that the specified requirements shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance. Adopted §3.3842(k) also addresses the applicability of the §3.3840 requirement of delivery of the shopper's guide. Adopted §3.3842(k) provides that both the §3.3842 requirements relating to suitability and the delivery requirements for the shopper's guide specified in §3.3840 shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

Section 3.3840, relating to the requirement of the delivery of the Long-Term Care shopper's guide, was not proposed for amendment in the proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635). Therefore, a change as requested by the commenters may not be made to existing §3.3840. Instead of modifying §3.3840 to address the requested exemption, the Department is adopting an exemption in §3.3842(l) for life insurance policies that under §3.3804(20) are eligible for the exemption. The booklet entitled "Long Term Care Insurance" published by the Texas Department of Insurance is the current "shopper's guide" in accordance with §3.3840(3). Adopted §3.3842(l) exempts from the requirement of delivery of the shopper's guide (booklet) for life insurance policies that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. The adopted exemption provides that in those instances of agent solicitation, an agent is not required to deliver a copy of the booklet prior to the presentation of an application or enrollment form for such policies. The adopted exemption further provides that in the case of direct response solicitations, the insurer is not required to present the booklet in conjunction with any application or enrollment form for such policies. In accordance with the definition of "long-term care insurance" in §3.3804(20), riders for group and individual annuities and life insurance policies that provide long-term care insurance are "long-term care insurance" and cannot be exempt from the shopper's guide delivery requirement. Therefore, adopted §3.3842(k) provides that §3.3842 requirements and the delivery requirements for the shopper's guide specified in §3.3840 of this subchapter shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

§3.3803(a)(2) and (3). Applicability and Severability.

Comment: Commenters object to proposed §3.3803(a)(2) and (3) for the following very similar and interrelated reasons: (i) the two provisions do not allow life and annuity products that provide long-term care coverage to be long-term care partnership policies while this is allowed under the Deficit Reduction Act of 2005; (ii) the two provisions are inconsistent with the require-

ments of the DRA because life and annuity products that provide long-term care benefits are able to meet all of the consumer protection requirements of the DRA; and (iii) the two provisions impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status.

Some commenters state that §3.3803(a)(2) includes life and annuity products that provide long-term care coverage under the definition and scope of "long-term care." These commenters also parenthetically indicate that the definition of "long-term care insurance" in §3.3804(20) also includes such products. The commenters opine, however, that §3.3803(a)(3) implies that life policies and annuities that provide long-term care coverage cannot be partnership program policies. According to the comments, this is inconsistent with the DRA. The commenters state that the DRA allows life and annuity products that provide long-term care coverage to be long-term care partnership policies.

Some commenters also object to §3.3803(a)(2) and (3) as proposed because they are inconsistent with the requirements of the DRA. The commenters note that the proposed partnership rules include the general requirement that all long-term care partnership insurance contracts must be "tax qualified" as defined in §7702B of the Internal Revenue Code and must meet certain other requirements as specified in the DRA. These other requirements include the requirement to include certain types of inflation protection at certain ages. The commenters conclude that as long as life and annuity products that provide long-term care coverage meet all of the consumer protection standards of the DRA, a carrier must be allowed to offer such products as partnership policies.

Some commenters further object to §3.3803(a)(2) and (3) as proposed, asserting that the DRA does not permit states to impose differing or additional standards on partnership policies. According to these commenters, §3.3803(a)(2) and (3) do impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status.

Agency Response: The Department disagrees with all three of the commenters' objections. Section 3.3803(a)(2) and (3) specify the applicability of the various sections of the long-term care rules. Section 3.3803(a)(2) specifies that §§3.3805 - 3.3849, which relate to non-partnership and partnership long-term care insurance, apply to non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804, except as specified in §3.3803(a)(5). Section 3.3803(a)(2) further provides that §§3.3805 - 3.3849 apply to long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state, except as specified in §3.3803(a)(5). Section 3.3803(a)(3) specifies that §3.3860 applies only to non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider, except as specified in §3.3803(a)(5). Section 3.3860 specifies the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Section 3.3803(a)(2) and (3) do not impose any substantive requirements but rather summarize the organization of the rules in Subchapter Y. The two provisions simply indicate which long-term care rules apply to: (i) non-partnership and partnership long-term care benefit plans; (ii) long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates; and (iii) non-partnership life insurance policies that provide long-term care benefits by rider.

The Department disagrees with the commenters' assertion that, under the DRA, life and annuity products that provide long-term care coverage are allowed to be long-term care partnership policies. The Department also disagrees that proposed §3.3803(a)(2) and (a)(3) are inconsistent with the requirements of the DRA and that life and annuity products that provide long-term care benefits are able to meet all of the consumer protection requirements of the DRA. The reasoning for this disagreement is discussed in the following.

Section 3.3803(a)(2) specifies that §§3.3805 - 3.3849 relate to non-partnership and partnership long-term care insurance. It further specifies that §§3.3805 - 3.3849 apply, except as otherwise specified, to (i) non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804, and (ii) long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates. Section 3.3803(a)(2) is consistent with the §3.3804(2) definition of "long-term care insurance" for the following reasons. The definition of "long-term care insurance" in §3.3804(20) defines which policies contain long-term care benefits, and of those policies, which are, and which are not, long-term care insurance for purposes of regulation in Texas. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), a partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). The Department's rules that implement the partnership program are required to contain these NAIC consumer protection requirements in accordance with the DRA. The Department has determined that it is consistent with the intent and purpose of the DRA that the definition of "long-term care insurance" in these rules be as consistent as possible with the definition of that term in the NAIC Long-Term Care Model Regulations and Model Act. The definition, however, must also be consistent with Texas law, §1651.003 of the Insurance Code. The NAIC definition of "long-term care insurance" in §4A of the NAIC Model Act provides in pertinent part that the term "long-term care insurance" includes group and individual annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Section 1651.003, however, is not consistent with this part of the definition. Section 1651.003(b) provides that the term "long-term care benefit plan" includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. The language "other than a group or individual annuity or life insurance policy," in §1651.003(b) excludes a group or individual annuity or life insurance policy from being long-term care insurance even if it provides for payment of benefits based on cognitive impairment or loss of functional capacity. It is therefore necessary that the definition of "long-term care insurance" used in the Department's partnership rules be consistent with the Insurance Code §1651.003(b). As a result, the §3.3804(20) definition cannot be totally consistent with the NAIC Model Act §4A definition of "long-term care insurance." The §3.3804(20) definition, consistent with the NAIC Model Act §4A definition, further specifies that with respect to life insurance the term "long-term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical

conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Therefore, the definition of "long-care insurance" in §3.3804(20) is consistent with the NAIC definition of long-term care insurance as modified for consistency with the Insurance Code §1651.003. It is also consistent with the intent and purpose of the DRA.

Additionally, the preceding analysis indicates that the applicability of the sections as specified in §3.3803(a)(2) is consistent with the §3.3804(20) definition of "long-term care insurance." Section 3.3803(a)(2) specifies that §§3.3805 - 3.3849 of the long-term care rules apply, except as otherwise specified, to (i) non-partnership and partnership long-term care benefit plans as defined in the Insurance Code §1651.003 and §3.3804, and (ii) to long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates. Because §3.3803(a)(2) is consistent with the §3.3804(20) definition of "long-term care insurance," it is also consistent with the NAIC definition of long-term care insurance as modified for consistency with the Insurance Code §1651.003. For this same reason, it is also consistent with the intent and purpose of the DRA. Therefore, the Department disagrees with the commenter's assertion that §3.3803(a)(2) is inconsistent with the requirements of the DRA.

As previously stated, the purpose of §3.3803(a)(3) is to specify the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in §3.3803(a)(5). The proposal published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5635) inadvertently omitted the reference to "annuity contracts" in proposed §3.3803(a)(3). Therefore, for purposes of clarity and consistency, §3.3803(a)(3) as adopted is changed to provide that §3.3860 applies not only to non-partnership life insurance policies, but also to annuity contracts, that provide long-term care benefits by rider except as specified in §3.3803(a)(5). Section 3.3860 relates to the policy summary requirements for non-partnership life insurance policies and annuity contracts that provide long-term care benefits. Under these requirements, a policy summary must be delivered with a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider at the same time that the policy or contract is delivered.

The DRA in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) requires the provisions of the NAIC Model Act §6J to be included in the long-term care partnership rules. Section 6J provides "At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy that provides long-term care benefits within the policy or by rider..." Section 6J(4) further requires that such policy summary shall include "a statement that any long-term care inflation protection option required . . . is not available under this policy." Section 6J(4) prohibits the offering or including of inflation protection in a life insurance policy that provides long-term care benefits within the policy or by rider. The Department has interpreted the §6J policy summary requirement and the §6J(4) prohibition to also apply to annuity contracts. Annuity contracts are not addressed in the NAIC Model Act §6J. Nevertheless, the Department's adopted rules apply the §6J policy summary requirement and the §6J(4) prohibition to annuity contracts in Texas. There are two reasons for this: (i) riders that meet the definition of long-term care are being attached to annuity contracts; and (ii) annuity products are regulated similarly to life insurance policies. Therefore, it is not possible for a life insurance policy or annuity contract that provides long-term care benefits within the policy or contract or by rider to meet the inflation protection requirements of the DRA. The definition of "long-term care insurance" in §3.3804(20) defines riders for group and individual annuities and life insurance policies that provide long-term care insurance as long-term care insurance. However, because of the NAIC Model Act §6J(4) prohibition, such policies and contracts cannot attain partnership status. Section 6J(4) is contained in §3.3860(a)(4) and §3.3820. Section 3.3803(a)(3), which specifies the applicability of §3.3860 to only non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider, is entirely consistent with the DRA. Therefore, the Department disagrees with the commenters' assertion that §3.3803(a)(3) is inconsistent with the requirements of the DRA. The Department also disagrees that the DRA allows life and annuity products to be long-term care partnership policies.

The Department agrees with the commenters' reasoning that the proposed partnership rules must include the general requirement that all long-term care partnership insurance contracts must be "tax qualified" as defined in §7702B of the Internal Revenue Code. The Department also agrees with the commenters' reasoning that the long-term care partnership policy must include certain types of inflation protection at certain ages. The Department, however, disagrees with the commenters' conclusion that life and annuity products are able to meet all of the consumer protection requirements necessary for partnership status just because these products provide long-term care benefits. As already discussed, one of the consumer protection requirements with which they cannot comply is the NAIC Model Act §6J(4) inflation protection requirement.

Therefore, the Department further disagrees with the commenters' objection to the rules because they impose differing or additional standards on life and annuity products that provide long-term care coverage by precluding such plans from partnership status. According to the commenters, this objection is based on the fact that the DRA prohibits states from imposing differing or additional standards on partnership policies. This prohibition is contained in §1917(b)(1)(C)(iii)(VII) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(VII)). It states: "The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirements on long-term care policies without regard to whether the policy is covered under the partnership or is offered in connection with such partnership." (emphasis added). Therefore, the Department agrees that the DRA does not permit states to impose differing or additional standards on life and annuity products that provide long-term care coverage. The standards, however, relating to life and annuity products in the Department's long-term care rules simply reflect the standards imposed by the federal DRA.

§3.3804(21). Definitions.

Comment: Some commenters indicate that the term "long-term care partnership insurance contract" as it is defined in §3.3804(21) is not used consistently throughout the text of the rules. The commenters note that the only time this term is used in the proposal is in §3.3874(c) and that generally, the references in the rules are to "long-term care insurance or policy."

Therefore, the commenters recommend that the defined term be changed to "long-term care partnership insurance policy."

Agency Response: The Department agrees. Therefore, the term defined in §3.3804(21) as adopted is "long-term care partnership insurance policy." For purposes of clarification, adopted §3.3804(21) is also changed to provide that the term may include an individual policy and/or a certificate and to provide that the term does not include a life insurance policy or annuity contract that provides long-term benefits by rider.

§3.3826(b) and (c). Limitations and Exclusions.

Comment: Commenters assert that the language regarding cross border limitations and exclusions is misplaced. While the commenters indicate agreement with the first sentence in §3.3826(b), they recommend that §3.3826(b)(1) and (b)(2) be moved to new §3.3826(c)(1) and (c)(2).

Agency Response: The Department agrees that the language regarding cross border limitations and exclusions is misplaced but does not agree with the commenters' suggestion on how to correct the misplacement. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §6B of the NAIC Long-Term Care Model Regulations relating to limitations and exclusions in a long-term care policy. Section 3.3826 as adopted has been changed to conform to the NAIC Model Regulations §6B(8) and (9). Section 3.3826 as proposed is not entirely consistent with NAIC Model Regulations §6B(8) and (9). The proposed text combines the prohibitions against limitations by type of provider and territorial limitations into one subsection. The Model Regulations recognize that these are two separate prohibitions. Section 3.3826 as adopted also recognizes the separate prohibitions against limitations by type of provider and territorial limitations.

§3.3829(b)(2)(E). Rate Increase Disclosure.

Comment: Some commenters request clarification regarding the Department's intent with respect to the addition of the phrase "individual or group" to §3.3829(b)(2)(E). The commenters express their understanding that if the Personal Worksheet is being used for individual insurance, a carrier only needs to disclose individual rate increases, not group rate increases.

Agency Response: The Department has determined from the comment received that the amendment to §3.3829(b)(2) adding the phrase "individual or group" has caused confusion and is deleting the phrase from §3.3829(b)(2) as adopted. The Department agrees with the commenters' understanding that when offering long-term care insurance in the individual market, the "Rate Increase History" information is only required to pertain to policies offered in the individual market. Likewise, when offering long-term care insurance in the group market, the "Rate Increase History" information is only required to pertain to policies offered in the group market.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet.

Comment: Some commenters support the use of the Personal Worksheet as detailed in the NAIC Model. However, the commenters object to the new section in the worksheet titled "Questions Related to Your Needs" and recommend that the entire section be removed from the worksheet due to its redundancy. According to the commenters, this new section is more appropriately and thoroughly addressed in multiple places including in the outline of coverage, the Shoppers Guide, and the disclosure form "Things You Should Know Before You Buy Long-Term Care Insurance." The commenters also assert that this section should be removed because it is inaccurately worded. For example, the second statement is incomplete as cognitive impairment can also trigger long-term care benefits.

Agency Response: The Department disagrees that the new section should be removed from the Personal Worksheet. The new section provides essential consumer information regarding the policy limitations on payment of long-term care benefits. The Department believes that this information is necessary for the applicant's careful consideration prior to purchasing a policy. Also, providing such information in the form of a question on the Personal Worksheet at the time the applicant is engaged in a dialogue with the agent is an extremely effective method of focusing the applicant's attention on matters directly relating to his/her purchase of the policy. The commenters are correct that this information is addressed in the multiple places listed in the comment. These sources, however, do not present the information in a question format that is more conducive to alerting and informing the potential purchaser. The other sources present the information in simple statements that are combined with many other important information items. This presentation makes the information less accessible to the consumer. Therefore, the Department disagrees that the new section should be deleted entirely. The Department, however, agrees with the comment that cognitive impairment can also trigger long-term care benefits. Therefore, the new section titled "Questions Related to Your Needs" has been changed accordingly in the Personal Worksheet as adopted.

Comment: One commenter requests removing the section in the Personal Worksheet titled "Questions Related to Your Needs" as proposed and replacing it with an alternative section. The alternative section would read in pertinent part:

Questions Related to Your Needs

You must be diagnosed with cognitive impairment or [Are you aware you need to] be unable to perform two (2) of the following six (6) activities of daily living (ADLs) - bathing, continence, dressing, eating, toileting, and moving around - prior to your long-term care benefits being *paid* [triggered]. *Do you understand this policy limitation?* __YES __NO

[Are you aware of the term "cognitive impairment? __YES __NO]

[Companies selling long-term care policies must offer a policy that pays benefits based on your cognitive impairment or your inability to perform two (2) ADLs. Do you understand this policy limitation? __YES __NO]

What type of long-term care service do you anticipate utilizing? (check all that apply)

__Nursing home care __Assisted living care __Home health care __Adult day care

__Hospice care __Respite care __other services

Does Policy Form [insert policy form number] cover all of the services checked above?

If not, which of the above mentioned services are included? Instructions to Company: Issuer must insert policy form number

and list appropriate services. If demonstrating multiple policy forms, reproduce this section separately for each form."

Agency Response: The Department agrees in part and disagrees in part with the recommended replacement section. The Department is changing the limitations on payment of policy benefits part of the "Questions Related to Your Needs" section in the adopted rules to follow the recommendation of the commenter except that the term "trigger" that was used in the proposal is being retained in the adopted rules in lieu of the suggested change to the term "paid." This is because the term "trigger" more accurately describes the action. In addition, the Department is changing the terminology "moving around" that was used in the proposal to the term "transferring." The reason for this change is that the term "transferring" is the proper and commonly used term for describing that particular ADL. Therefore, the pertinent part of the notice as adopted reads: "You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADL's)-bathing, continence, dressing, eating, toileting, and transferring--prior to your long-term care benefits being triggered. This will clarify that cognitive impairment can also trigger long-term care benefits. The Department, however, disagrees with adding the new questions recommended by the commenter. The questions concern whether the policy form that the agent is demonstrating to the applicant covers all of the long-term care services that the applicant has checked and if not, which of the services are included in the policy. The Department also disagrees with adding the recommended Instructions to Company that would require the insurer to reproduce these questions separately for each policy form being demonstrated if multiple policy forms are being demonstrated to an applicant. These recommended additions are redundant, and the Department, therefore, does not believe that they are necessary. The Outline of Coverage, which is required to be delivered to the applicant, includes the policy or certificate number and describes the benefits provided by the policy.

Comment: One commenter requests adding to the section of the Personal Worksheet on "Questions Related to Your Income" and prior to the questions concerning the elimination period an explanation of the "elimination period" for a long-term care policy. The commenter suggests the following language: "Most long-term care policies contain an elimination period. An elimination period is the number of days you must receive and pay for the services that are covered under the policy before the policy will pay any benefits."

Agency Response: The Department disagrees that the requested addition to the Personal Worksheet is needed. The Personal Worksheet requires the applicant to consider the number of days that he/she is selecting and to evaluate how the applicant will pay for care during the elimination period. The key factors an applicant needs to be aware of with respect to an elimination period are: (i) knowing they have to pay for care during the elimination period; and (ii) evaluating whether they are able to do so. The addition of the requested definition will not assist an applicant in his/her awareness of these key factors for evaluating the elimination period for a long-term care policy.

§3.3829(b)(8)(H). Long-Term Care Insurance Personal Worksheet.

§3.3829(b)(8)(I). Long-Term Care Insurance Potential Rate Increase Disclosure Form.

Comment: Some commenters request a delayed one-year effective date on use of the Personal Worksheet because a year is needed to file the form, have it approved, and moved into production. Some commenters request a one-year delayed effective date on use of the Potential Rate Increase Disclosure Form to allow insurers sufficient time to file the form, receive Department approval, and produce the form.

Agency Response: The Department disagrees with the requested delay. The Personal Worksheet provides information for the insurer to use to assess the applicant's suitability to purchase a long-term care policy prior to the applicant's purchase of the policy. The Personal Worksheet provides the important consumer protection of assisting the applicant and the insurer in making an informed decision as to whether it is prudent for the applicant to purchase a long-term care policy given the financial circumstances of the applicant. Delaying the use of the Personal Worksheet as requested by the commenters would deprive long-term care policy applicants of these important consumer protections for a full year. The Department, however, understands that insurers may need additional time to print and distribute the Personal Worksheet. Therefore, the Department is adopting new §3.3829(c) to specify the effective dates and certain other requirements for use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form. Adopted new §3.3829(c) also provides insurers with additional time to print and distribute the new forms. Adopted §3.3829(c)(1) provides that in lieu of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form insurers may use until December 31, 2009 the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs." New §3.3829(c)(3) specifies that insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department. New §3.3829(c)(4) requires that on and after January 1, 2010, all insurers must use Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in §3.3829(b)(8)(I) in accordance with all of the requirements specified for these two forms in §3.3829.

§3.3837(f). Reporting Requirements for Suitability Data.

Comment: Some of the commenters object to the requirement in §3.3837(f) for carriers to report suitability data on both Partnership and non-Partnership policies because it is overly burdensome. The commenters recommend that, if the Department elects to move forward with the additional suitability reporting requirements for non-Partnership policies, a delayed implementation is needed. The commenters recommend that the first data be reported in 2010 for calendar year 2009.

Agency Response: The new §3.3837(f) requirements for reporting suitability data are necessary for the Department to have an understanding of what is going on in the marketing practices of those insurers that market partnership policies as well as those insurers that market non-partnership policies. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The data will assist the Depart-

ment in identifying possible improper marketing practices and will enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. It appears that the commenters have misinterpreted §3.3837(f) concerning the time for the first suitability data to be reported. Under the proposal and the adoption, the implementation of the suitability data reporting for both Partnership and non-Partnership policies is for calendar year 2009 with the Long-Term Care Suitability Reporting Form for the reporting year 2009 to be filed with the Commissioner by June 30, 2010. The Department's timeline for the first suitability reporting is the same as that recommended by the commenters.

§3.3842. Appropriateness of Recommended Purchase.

Comment: One commenter expresses concern that proposed §3.3842 allows each insurer to develop their own suitability standards. The commenter opines that the Department should specify additional suitability standards for insurers and also require each insurer to file their suitability standards for approval by the Department.

Agency Response: The Department disagrees with the commenter's recommendations. Pursuant to §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)), the partnership policy must meet the consumer protection requirements of the NAIC Long-Term Care Model Regulations and Model Act that are specified in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)). These NAIC consumer protection requirements for partnership policies include the provisions in §24 of the NAIC Long-Term Care Model Regulations relating to suitability. The regulatory framework in §3.3842 is consistent with §24. Section 3.3842 provides specific guidelines to insurers for developing their suitability standards. Also, §3.3842 requires insurers to maintain a copy of their suitability standards and to make them available for inspection upon request by the Commissioner.

§3.3842(i)(7). Long-Term Care Suitability Form ("Things You Should Know").

Comment: Some commenters request a delayed one-year effective date on use of the Long-Term Care Suitability Form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" that is required in §3.3842(i)(7). The request is based on the fact that this is a new form not currently in use, and a year is needed to file the form, have it approved, and moved into production.

Agency Response: The Department disagrees that insurers need the requested delay of a one-year effective date. Under §3.3842(i)(7), there is no filing and approval requirement for the "Things You Should Know Before You Buy Long-Term Care Insurance" form unless the insurer changes the format of the mandated text. Insurers may print and use the form that is specified in §3.3929(i)(7) without having to file the form for approval. The DRA in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) requires that insurers use this form and the disclosures contained in this form immediately upon marketing

Comment: One commenter recommends that to help consumers in evaluating the quality of potential long-term care services that a link to the Texas Department of Aging and Disability Services be included in the "Things You Should Know Before You Buy Long-Term Care Insurance" form. The link would refer one to the Long-Term Care Quality Reporting System in the "Facilities" section on the website of the Aging and Disability Services Department. The commenter suggests the following language: "To find and compare long-term care providers, visit the Texas Department of Aging and Disability Services website at http://www.dads.state.tx.us/."

Agency Response: The Department declines to make the recommended change. The link refers one to the Long-Term Care Quality Reporting System which provides comparative individual provider information concerning facility inspections and results of complaint investigations for the various classifications of long-term care facilities that are located in each county of the state. This information is intended to assist individuals who are actively seeking to locate a long-term care facility for immediate occupancy. While the provider information on the Long-Term Care Quality Reporting System website is useful to an insured who may be actively seeking to locate a long-term care facility for immediate occupancy, it has limited value to applicants who probably will not need services for several years. The most appropriate resource for providing assistance to applicants in deciding whether or not to purchase long-term care insurance is the Texas Health Information Counseling and Advocacy Program (HICAP) that provides free one-to-one counseling concerning the applicant's suitability to purchase long-term care insurance. The (HICAP) information is contained in the Counseling section of the "Things You Should Know Before You Buy Long-Term Care Insurance" form.

§3.3842(j). Appropriateness of Recommended Purchase.

Comment: Several commenters request greater "flexibility" in the language of the proposed suitability letter specified in §3.3842(j). The commenters recommend amending the first sentence of §3.3842(j) to allow the issuer to send a letter similar to the letter specified in §3.3842(j).

Agency Response: The Department agrees, and §3.3842(j) as adopted allows insurers to send the applicant a suitability letter in accordance with or similar to the letter specified in §3.3842(j). Adopted §3.3842(j) provides in the first sentence that if the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with or similar to Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. In addition, because of the change to the first sentence in §3.3842(j), conforming changes have been made to §3.3842(j)(1) and (j)(2). The modified language in §3.3842(j)(1) as adopted reads: "The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j) or be similar to the text specified in Figure: 28 TAC §3.3842(j)." Additionally, the modified language in §3.3842(j)(2) as adopted deletes the requirement that the text must follow the order of the information presented in Figure: 28 TAC §3.3842(j).

§3.3848. Limited Premium Payment Requirements.

Comment: Some commenters assert that it is not clear in §3.3848 that the requirements of the section apply only to policies with a payment period of 10 years or less. The commenters request that to clarify this point the following statement be added to the end of subsection (a): "...Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10-years. Nor will such options be subject to this section."

Agency Response: The Department agrees with the comment, and the requested change has been made in §3.3848(a) as adopted.

Comment: Some commenters object to proposed §3.3848(b)(3), (4), and (5)(A) because they do not contain an alternative that will allow the required renewability provision to be added to the policy via an endorsement or change to the schedule page. The commenters point out that the rule has a requirement that the Department can only approve a limited pay plan on a separate policy series. The commenters state that under §3.3848(b) the Department is essentially continuing that same mandate by requiring disclosure on the policy cover. Most carriers in virtually all states implement limited pay disclosures through an endorsement on the schedule page. The commenters request that the following language be added to the end of each of the provisions in §3.3848(3), (4) and (5)(A): "In the alternative, the required renewability provision may be added to the policy via an endorsement or change to the schedule page."

Agency Response: The Department disagrees with this recommended change. There is no requirement that only a limited pay plan on a separate policy series can be approved by the Department. Insurers are permitted to offer limited pay premium by endorsement and proper disclosure on the cover page. Therefore, §3.3848(b)(3), (4), and (5)(A) as adopted include the following provision: "In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page."

Comment: Some commenters request that varying methods of disclosure be allowed for use with limited pay period policies and recommend that §3.3848(b)(1) as proposed be changed as follows: "(1) Notice. [The face page of a] A long-term *care insurance* policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option."

Agency Response: The Department agrees. Section 3.3848(b)(1) as adopted contains the requested change in language.

Comment: One commenter asserts that the consumer protections provided in §3.3848 against cancellation, changes in the policy, and return of premium when combined with the commenter's alleged inadequacies of the suitability standards in the proposal may present difficulties in analyzing and detecting exploitive sales patterns. The commenter recommends a mechanism to detect whether agents are making inappropriate use of the limited pay options. The commenter states that the lack of certain information on the Personal Worksheet and the opportunity to prepay the policy may provide incentive for agents to inappropriately encourage applicants to use the limited pay options.

Agency Response: The Department understands the commenter's concerns. The Department, however, does not agree with the recommendation to add a specific mechanism to detect whether agents are making inappropriate use of the limited pay options because such market conduct monitoring mechanisms are already in place. The Department has several different tools to monitor insurers' market conduct to detect and analyze exploitive sales patterns. One of the most important tools is the new suitability reporting requirements in §3.3837(f) for all insurers that market long-term care insurance policies in Texas. It is anticipated that the new suitability reporting requirements and the new reporting form will provide the Department with important information regarding the appropriateness of the marketing and sales of long-term care policies to Texas consumers. The data will provide an essential tool in the Department's monitoring of whether long-term care policies are being sold appropriately, i.e., to those who actually need the coverage. The data will assist the Department in identifying possible improper marketing practices and will thereby enable the Department to act more quickly and efficiently to resolve such problems before they result in harm to consumers. Another important tool for monitoring and detecting exploitive sales patterns is the ongoing monitoring of consumer complaints by the Department's Consumer Protection Division. If the Consumer Protection Division begins to see a pattern of complaints that involve a particular company then the company will be referred for further evaluation and a possible market conduct examination.

Comment: One commenter requests that an additional requirement be added to §3.3848 that provides that an applicant who is considering a limited premium payment policy be provided a comparison to a policy that provides a "regular" monthly premium.

Agency Response: The Department does not agree that such a requirement is necessary at this time. The Department is not aware of any circumstances that suggest problems that would warrant such a requirement. However, if the Department receives complaints that indicate that such a comparison requirement is needed, the Department will consider an amendment to address the issue.

§3.3870. Partnership Exchanges.

Comment: Some commenters request that the requirement to offer exchanges be extended to allow insurers 18 months from the date the insurer initiates its partnership program to implement an exchange program. Proposed §3.3870 provides that the insurer is required to offer the option to exchange by December 31, 2009. These commenters also request that the offer to exchange be limited to insureds under a policy or certificate "of the type certified" by the insurer (e.g., if an insurer certifies an individual policy for partnership, certificate holders under a group policy should not be required to receive an offer of exchange for the individual partnership policy). These commenters recommend changing §3.3870(a) to read as follows:

"(a) Notification and Offer to Exchange. *Within 18 months from the date that an insurer* [Any insurer that] begins to advertise, market, offer or sell [or issue] policies [that qualify] under the Texas Long-Term Care Partnership Program, *the insurer* is required to offer on a one-time basis, *in writing*, to all policyholders [and] or certificate holders that were issued long-term care coverage *of the type certified* by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate. [The insurer is required to offer the option to exchange in writing by December 31, 2009.]"

Agency Response: The Department agrees with the comments and §3.3870(a) as adopted is changed accordingly.

Comment: Some commenters recommend that carriers be allowed to develop exchange programs that may differ from the procedures and requirements specified in proposed §3.3870. These commenters recommend that a new subparagraph (C) be added to §3.3870(b)(2) as follows:

"(C) In lieu of paragraphs (A) and (B) above, an insurer may implement an alternative exchange methodology or program so

long as such methodology or program meets the intent of this section and is filed with and approved by the Commissioner."

Agency Response: The Department agrees with the recommendation that carriers be allowed to develop alternative exchange programs. However, the Department does not agree with the specific recommended language. The recommended language is vague and lacks sufficient specificity for rule implementation and compliance enforcement. Therefore, in lieu of the recommended language, the Department is adopting the following provision in §3.3870(b)(2)(C): "In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings)."

§3.3870(e). One-time Exchange Reporting Requirement.

Comment: Some commenters object to proposed §3.3870(e) which requires the carriers to report exchanges on the Long-Term Care Insurance Replacement and Lapse Reporting Form for calendar year 2009. According to the commenters, it is preferable to report exchanges separately because carriers will have to reprogram their replacement reporting systems for this onetime reporting requirement.

Agency Response: The Department has changed §3.3870(e) as adopted to require an insurer to report exchanges made pursuant to §3.3870 on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program. This change is necessitated by the change to §3.3870(a) as adopted which provides each individual insurer with an 18-month time period from the date that the insurer initiates its partnership program to implement an exchange program. This modification to §3.3870(a) also requires a revision in the time frame for the reporting of exchanges specified in §3.3870(e). The purpose of the reporting requirements in §3.3870(e) is to ensure that exchanges are not reported as replacements.

§3.3871. Disclosure Notice.

Comment: Several commenters express concern that the statement in the last sentence of the first paragraph of the Disclosure Notice may be misleading. According to the commenters, the laws in Texas may change, and it would be clearer to consumers if the statement is not absolute but that their rights are based on the current law. The commenters recommend that this statement be removed, or if included, that it be revised as follows:

"[In accordance with the] Texas Insurance Code [§1651.106], 1651.105 *currently* provides that if the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the partnership program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the Texas Medicaid Program."

Agency Response: The Department disagrees that the statement may be misleading. The sentence states §1651.106 of the Insurance Code and is clear and readily understandable. It does not require any further explanation or refinement. Section 1651.105 is an incorrect citation. Section 1651.105 pertains to the required training for agents and does not address the effect of discontinuation of the partnership program on a partnership policy.

Comment: Several commenters point out that the disclosure notice in the last sentence of the paragraph titled "What Could Disqualify Your Policy Status as a Partnership Policy" incorrectly refers to the disclosure notice as an "Endorsement." The commenters recommend that the words "Disclosure Notice" be substituted for "Endorsement."

Agency Response: The Department agrees and the disclosure notice as adopted has been changed accordingly.

§3.3872. Inflation Protection Requirements.

Comment: One commenter opposes offering inflation protection at a rate of less than 3 percent and recommends requiring inflation protection of no less than 3 percent on all long-term care partnership policies.

Agency Response: The Department disagrees with the recommendation. The Department understands the commenter's concern that inflation will erode the utility of a long-term care policy over time. The Department, however, is also very concerned with maintaining the affordability of long-term care partnership policies. Inflation protection at any percentage is a costly feature of a long-term care policy. The inflation protection requirements in §3.3872 are intended to balance affordability of a long-term care policy with the need to protect consumers from the escalating costs of long-term care.

Comment: One commenter expresses concern that insureds have the option of dropping inflation protection for partnership policies when they reach the age of 76.

Agency Response: The Department understands the commenter's concern. Section 1917(b)(1)(C)(iii)(IV)(cc) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV))cc)), however, clearly provides that if a partnership policy is sold to an individual who has attained age 76 as of such date, the policy may but is not required to provide some level of inflation protection. Affordability is a major concern with the purchase of a long-term care policy. Many individuals in retirement often have a lower income than they did during their working years. And in many instances, this income is a fixed income. The option of dropping inflation protection when an individual reaches the age of 76 will provide these individuals with the flexibility to reduce their premiums at a time when a reduction might be most needed.

§3.3874. Insurer Requirements for Agents that Market Partnership Policies and Certificates.

Comment: Some commenters request an exemption from the agent training and certification requirements in §3.3874 that would also apply to financial advisors who refer applicants for long-term care policies to trained and certified agents. These requirements include an eight-hour training course and a subsequent continuing education course every two years. The commenters assert that the training and certification requirements are overly burdensome for financial advisors. The commenters state that financial advisors should not have to undergo the training and certification requirements if they are working with agents who are certified and trained. The financial advisor is not the agent of record but receives commissions.

Agency Response: Whether a financial advisor must be licensed as an insurance agent and comply with the agent training and certification requirements in §3.3874 is determined by the actual functions performed by the financial advisor. It is also based on the referral fee or commission arrangement of the individual financial advisor with the licensed insurance agent. Sec-

tion 1651.105 of the Insurance Code specifies that each individual who sells a long-term care partnership policy must complete training and demonstrate evidence of an understanding of these policies and how they relate to other public and private coverage of long-term care. The statute further specifies that each insurer that issues a long-term care partnership policy shall certify to the Commissioner that the individual who sells the policy has received the required training. A person who performs an act of an agent, as specified in the Insurance Code §4001.051, is required to hold the appropriate agent license. Section 4001.051(b) provides that regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by the Insurance Code Title 13, Chapter 21, or a provision listed in §4001.009 if the person: (i) solicits insurance on behalf of the insurer; (ii) receives or transmits other than on the person's own behalf an application for insurance or an insurance policy to or from the insurer; (iii) advertises or otherwise gives notice that the person will receive or transmit an application for insurance or an insurance policy; (iv) receives or transmits an insurance policy of the insurer; (v) examines or inspects a risk; (vi) receives, collects, or transmits an insurance premium; (vii) makes or forwards a diagram of a building; (viii) takes any other action in the making or consummation of an insurance contract for or with the insurer other than on the person's own behalf; or (ix) examines into, adjusts, or aids in adjusting a loss for or on behalf of the insurer. Section 4001.051(d) provides that the referral by an unlicensed person of a customer or potential customer to an agent is not an act of an agent under this section unless the unlicensed person discusses specific insurance policy terms or conditions with the customer or potential customer. Under §4005.053(c)(2), an unlicensed person may receive a fee or other valuable consideration for referring a customer who seeks to purchase an insurance product or seeks an opinion on or advice regarding an insurance product, so long as the fee or other valuable consideration is not based upon that customer's purchase of insurance. Therefore, certain financial advisors are required to be licensed as agents and to have the §3.3874 training and certification. These financial advisors include those who (i) receive referral fees or commissions based upon a customer's purchase of insurance; (ii) receive a fee or commission based on the percent of the policies sold; or (iii) discuss specific insurance policy terms or conditions with the customer or potential customer. Financial advisors who are not required to be licensed as agents and who are not required to have the §3.3874 training and certification include those who: (i) only advise a client to purchase a long-term care insurance policy; (ii) do not discuss the insurance policy terms and conditions; (iii) only provide the name of an agent or agents to the client; and (iv) either do not get paid based on the customer purchasing the policy or who receive only a flat fee for client referrals.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For with changes: American Health Insurance Plans and American Council of Life insurers.

Neither for nor against: American Association of Retired Persons - Texas.

For with changes: Office of Public Insurance Counsel.

Neither for nor against: LTC Financial Partners.

DIVISION 1. GENERAL PROVISIONS

28 TAC §§3.3801 - 3.3804

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and 36.001; and §1917(b) of the Social Security Act as amended by §6021 of the Deficit Reduction Act of 2005 (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. SB 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Texas Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the

Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code; (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act; (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership; (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA; and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

§3.3803. Applicability and Severability.

(a) Applicability.

(1) In accordance with the Insurance Code Chapter 1651, §§3.3801 - 3.3804 of this subchapter (relating to General Provisions) apply to all long-term care insurance coverage that is regulated under this subchapter.

(2) In accordance with the Insurance Code Chapter 1651, §§3.3805 - 3.3807, 3.3810, 3.3812, 3.3815, and 3.3818 - 3.3849 of this subchapter (relating to Non-Partnership and Partnership Long-Term Care Insurance) apply to all non-partnership and partnership long-term care benefit plans as that term is defined in the Insurance Code §1651.003 and §3.3804 of this subchapter (relating to Definitions), and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection.

(3) In accordance with the Insurance Code Chapter 1651 Subchapter C (relating to Partnership for Long-Term Care Program), §3.3860 of this subchapter (relating to Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits) applies only to non-partnership life insurance policies and annuity contracts that provide long-term care benefits by rider except as specified in paragraph (5) of this subsection.

(4) In accordance with the Insurance Code Chapter 1651 Subchapter C, §§3.3870 - 3.3874 of this subchapter (relating to Partnership Long-Term Care Insurance Only) apply only to long-term care partnership benefit plans as that term is defined in the Insurance Code §1651.101 and §1651.104 delivered or issued for delivery in this state except as specified in paragraph (5) of this subsection.

(5) In accordance with the Insurance Code §1651.002, this subchapter does not apply to:

(A) certificates delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(B) a policy or certificate that is not designed, advertised, marketed, or offered as long-term care or nursing home insurance.

(b) Severability. If any provision of the sections in this subchapter or its application to any person or circumstance is held to be invalid, such invalidity shall not affect other provisions or applications which can be given effect without the invalid provisions, and to this end, the provisions of each section are declared to be severable.

§3.3804. Definitions.

(a) Except as otherwise provided by law or this subchapter, no long-term care insurance policy, certificate, group hospital service corporation subscriber contract, rider attached to a life insurance policy or certificate or annuity contract or certificate may be delivered or issued for delivery in this state, unless it complies with, and contains definitions in conformance with, this subchapter.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Activities of daily living--Bathing, continence, dressing, eating, toileting and transferring, as those terms are defined in this subsection.

(2) Acute condition--The individual's medical condition is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) Adult Day Care--A social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

(4) Adult Day Care Facility--Provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

(5) Applicant--The person who seeks to contract for benefits or services, in the instance of an individual long-term care insurance policy; or the proposed certificate holder or enrollee, in the instance of a group long-term care insurance policy.

(6) Attained age rating--A schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(7) Bathing--Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(8) Care--Terms referring to care, such as "home health care," "intermediate care," "maintenance or personal care," "skilled nursing care," and other services, shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.

(9) Certificate--Any certificate issued under a group long-term care insurance policy, which certificate has been delivered or issued for delivery in this state. For purposes of these sections, the term:

(A) Also includes any evidence of coverage issued pursuant to a group health maintenance organization contract for long-term care health coverage.

(B) Does not include certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(10) Continence--The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(11) Dressing--Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(12) Eating--Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(13) Exceptional premium rate increases--Increases filed by an insurer as exceptional and for which the department determines the need for the premium rate increase is justified:

(A) due to changes in laws or regulations applicable to long-term care coverage in this state; or

(B) due to increased and unexpected utilization that affects the majority of insurers of similar long term care products.

(14) Group long-term care insurance--A long-term care insurance policy or certificate of group long-term care insurance that is delivered or issued for delivery in this state and issued to an eligible group as defined by the Insurance Code Chapter 1251 Subchapter B (relating to Group Accident Health Insurance: Eligible Policyholders) but subject to the exemptions in the Insurance Code §1651.002 (relating to Exemptions), or a long-term care rider issued to an eligible group as defined by the Insurance Code §1131.002 (relating to Certain Group Life Insurance Authorized).

(15) Home health agency--A business which provides home health service and is licensed by the Texas Health and Human Services Commission.

(16) Home health care services--Medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

(17) Level premium long-term care policy--A non-cancellable long-term care policy.

(18) Long-term care benefit classifications--Institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(19) Long-term care benefit plan--An insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Insurance Code Chapter 843) that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. Pursuant to the Insurance Code §1651.003(b), the term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or for the loss of functional capacity. The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage or basic or single health care services. With regard to life insurance, this term does not include life insurance policies:

(A) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(B) that provide the option of a lump-sum payment for those benefits; and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(20) Long-term care insurance--

(A) Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care. The term includes riders for group and individual annuities and life insurance policies that provide long-term care insurance. The term also includes a policy, certificate, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care insurance contracts. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; and health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance.

(B) The term "long-term care insurance" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or asset-related protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(C) With regard to life insurance, this term does not include life insurance policies:

(i) that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(ii) that provide the option of a lump-sum payment for those benefits; and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(D) Notwithstanding any other provision of this subchapter, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this subchapter.

(21) Long-term care partnership insurance policy--A long-term care insurance policy and/or certificate established under the Human Resources Code Chapter 32 Subchapter C and that meets the requirements of the Federal Deficit Reduction Act of 2005, Pub. L. No. 109-171 and Chapter 1651 Subchapter C of the Insurance Code. This term does not include a life insurance policy or annuity contract that provides long-term care benefits by rider.

(22) Maintenance or Personal Care Services--Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this subchapter (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

(23) Medicare--"The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(24) Mental or Nervous Disorder--A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(25) Policy--Any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit group hospital service corporation, or health maintenance organization subject to the Texas Health Maintenance Organization Act Insurance Code Chapter 843.

(26) Preexisting Condition--A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(27) Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(28) Qualified long-term care insurance contract--A long-term care insurance contract meeting the requirements as contained in Internal Revenue Code of 1986, §7702B(b).

(29) Qualified long-term care services--As the term is defined in Internal Revenue Code of 1986, §7702B(c).

(30) Similar policy forms--All of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Those certificates issued or delivered pursuant to one or more employers or labor union organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(31) Toileting--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(32) Transferring--Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Department of Insurance
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DIVISION 2. NON-PARTNERSHIP AND PARTNERSHIP LONG-TERM CARE INSURANCE

28 TAC §§3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, 3.3846, 3.3848, 3.3849

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and 36.001; and §1917(b) of the Social Security Act as amended by §6021 of the Deficit Reduction Act of 2005 (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. Senate Bill (SB) 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Texas Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA expands State Long-Term Care Partnership Programs, which encour-

age individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code; (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act; (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership; (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA; and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

§3.3826. Limitations and Exclusions.

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(1) a preexisting condition or disease, as defined in §3.3804(b) of this subchapter (relating to Definitions); and §3.3824 of this subchapter (relating to Preexisting Conditions Provisions);

(2) mental or nervous disorders; however, this shall not permit exclusion or limitations of benefits on the basis of the following:

(A) Alzheimer's disease or related disorders, where a clinical diagnosis of Alzheimer's disease by a physician licensed in this state, including history and physical, neurological, psychological and/or psychiatric evaluation, and laboratory studies, has been made to satisfy any requirement or demonstrable proof of organic disease or other proof under the coverage; or

(B) biologically based brain diseases/serious mental illness, including schizophrenia, paranoid and other psychotic disorders, bipolar disorders (mixed, manic, and depressive); major depressive disorders (single episode or recurrent); and schizo-affective disorders (bipolar or depressive);

(3) alcoholism and drug addiction;

(4) illness, treatment, or medical condition arising out of any of the following:

(A) war or act of war, whether declared or undeclared;

(B) participation in a felony, riot, or insurrection;

(C) service in the armed forces or units auxiliary thereto;

(D) suicide, attempted suicide, or intentionally self-inflicted injury; or

(E) aviation activity as a nonfare-paying passenger;

(5) treatment provided in a governmental facility (unless otherwise required by law); benefits provided under Medicare or other governmental program (except Medicaid); any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance; or

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(b) This section is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care insurer may deny a claim because services are provided in a state other than the state of policy issue under the conditions specified in paragraphs (1) and (2) of this subsection:

(1) when the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(2) when the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(3) For purposes of this subsection, "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(c) Provisions of this section are not intended to prohibit territorial limitations.

§3.3829. Required Disclosures.

(a) Required Disclosure of Policy Provisions.

(1) Long-term care insurance policies and certificates shall contain a renewability provision as required by §3.3822 of this subchapter (relating to Minimum Standard for Renewability of Long-term Care Coverage). Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder under a long-term care insurance policy and/or certificate, all riders or endorsements added to a long-term care insurance policy and/or certificate after the date of issue or at reinstatement or renewal, which reduce or eliminate benefits or coverage in the policy and/or certificate, shall require a signed acceptance by the policyholder. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage are required by law. Where a separate additional premium

is charged for benefits in connection with riders or endorsements, such premium charge shall be set forth in the policy, certificate, rider, or endorsement.

(3) A long-term care insurance policy and certificate which provides for the payment of benefits on standards described as usual and customary, reasonable and customary, or words of similar import, shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in the Insurance Code Chapter 1651 or §3.3824 of this subchapter (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy or certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates shall appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates shall contain a claim denial provision which shall be appropriately captioned. Such provision shall clearly state that if a claim is denied, the insurer shall make available all information directly relating to such denial within 60 days of the date of a written request by the policyholder or certificate holder, unless such disclosure is prohibited under state or federal law.

(9) A long-term care insurance policy and certificate which includes benefit provisions under §3.3818(b) of this subchapter (relating to Standards for Eligibility for Benefits) shall disclose, within a common location and in equal prominence, a description of all benefit levels payable for the coverage described in §3.3818(b) of this subchapter. Criteria utilized to determine eligibility for benefits shall be disclosed in all long-term care insurance policies and certificates, in the manner prescribed by §3.3818 of this subchapter.

(10) If the insurer intends for a long-term care insurance policy or certificate to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b)."

(11) If the insurer does not intend for the policy to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is not intended to be a qualified long-term care insurance contract. This long-term care insurance policy does not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B."

(12) A long-term care policy or certificate which provides for increases in rates shall include a provision disclosing that notice of an upcoming premium rate increase will be provided no later than the 45th day preceding the date of the implementation of the rate increase.

(b) Required Disclosure of Rating Practices.

(1) Other than non-cancellable policies or certificates, the required disclosures of rating practices set forth in paragraph (2) of this subsection shall apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection shall apply on the policy anniversary following January 1, 2003.

(2) Insurers shall provide the following information as set forth in this paragraph and Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information shall be provided at the time of delivery of the policy or certificate:

(A) a statement that the policy may be subject to rate increases in the future;

(B) an explanation of potential future premium rate revisions, including an explanation of contingent nonforfeiture benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(C) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(D) a general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) a description of when premium rate or rate schedule adjustments will become effective (e.g., next anniversary date, next billing date, etc.); and

(ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this paragraph if the premium rate or rate schedule is changed;

(E) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

(i) the policy forms for which premium rates have been increased;

(ii) the calendar years when the form was available for purchase; and

(iii) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and also may be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(3) Subsequent to the information required by paragraph (2) of this subsection, insurers may, in a manner that is not misleading, provide in addition to the information required in paragraph (2)(E) of this subsection, explanatory information related to the rate increases.

(4) Insurers may exclude from the disclosure required by paragraph (2)(E) of this subsection premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(5) If an acquiring insurer files for a rate increase either on a long-term care policy form acquired from a nonaffiliated insurer, or on a block of policy forms acquired from a nonaffiliated insurer on or before January 1, 2002 or the end of the 24-month period after the date of the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with paragraph (2)(E) of this subsection.

(6) If the acquiring insurer in paragraph (5) of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer referenced in paragraph (5) of this subsection, the acquiring insurer shall make all disclosures required by paragraphs (2)(E), (3), (4) and (5) of this subsection.

(7) An applicant shall sign an acknowledgement at the time of application that the insurer has made the disclosure(s) required under paragraph (2) of this subsection. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(8) An insurer shall use the text for Form Number LHL560(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) to comply with the requirements in paragraph (2)(A) and (E) of this subsection and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(I) to comply with the requirements in paragraph (2)(B), (C), and (D) of this subsection. The effective dates for use of each form are specified in subsection (c) of this section. The following requirements and procedures apply to Form Number LHL560(LTC) and Form Number LHL561(LTC):

(A) The text in each form must be in at least 12-point type and must follow the order of the information presented in the form.

(B) The text and order of presentation of information in each form are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) if the insurer files the forms for review and approval by the commissioner as provided in subparagraphs (C) and (F) of this paragraph.

(C) Any form filed pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(D) An insurer may add a company name and identifying form number to Form Number LHL560(LTC) and Form Number LHL561(LTC) as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) without obtaining commissioner approval.

(E) The Instructions to Company that are included in Figure: 28 TAC §3.3829(b)(8)(H) and Figure: 28 TAC §3.3829(b)(8)(I) are to aid the insurer in drafting the forms and should not be included in the text of the forms used by the insurer.

(F) The forms filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(G) Persons may obtain the required form by making a request to the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department's website at www.tdi.state.tx.us.

(H) A representation of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet is as follows:
Figure: 28 TAC §3.3829(b)(8)(H)

(I) A representation of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form is as follows:
Figure: 28 TAC §3.3829(b)(8)(I)

(9) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (2)(B), (C), and (D) of this subsection and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) when the rate increase is implemented. The notice shall comply with the requirements specified in Figure: 28 TAC §3.3829(b)(8)(I).

(c) Effective Dates for Use of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form.

(1) In lieu of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H), insurers may use until December 31, 2009, the standard NAIC Long-Term Care Insurance Personal Worksheet and a Texas Supplement printed on a separate sheet that contains the "Questions Related to Your Needs."

(2) In lieu of Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I), insurers may use until December 31, 2009, the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form, LTC RATE INCR DISC-01-2002, that is currently being used in Texas. Insurers are not required to include the "Rate Increase History" information on the "Texas" Long-Term Care Insurance Potential Rate Increase Disclosure Form but are required to include such information on the standard NAIC Long-Term Care Insurance Personal Worksheet.

(3) Insurers are not required to file the standard NAIC Long-Term Care Insurance Personal Worksheet or the Texas Supplement for review and approval by the Department.

(4) On and after January 1, 2010, all insurers must use Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form specified in Figure: 28 TAC §3.3829(b)(8)(I)

in accordance with all of the requirements specified for these two forms in this section.

§3.3830. Requirements for Application Forms and Replacement Coverage.

(a) Individual, direct-response-solicited, and group long-term care insurance application forms shall include questions designed to elicit information as to whether, as of the date of application, the applicant has another long-term care insurance policy or certificate in force or the proposed insurance is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to an employer, labor union, or continuing care retirement community, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement. The following questions shall be included in the application.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(A) If so, with which company?

(B) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

(4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(b) Agents shall list any other health insurance policies and certificates they have sold to the applicant and shall also:

(1) list policies and certificates sold which are still in force;

(2) list policies and certificates sold in the past five years which are no longer in force.

(c) Agents shall list any other health insurance policies or certificates the applicant has in force.

(d) Upon a determination that a sale will involve replacement, an insurer or its agent, if that insurer is other than one using direct-response solicitation methods, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner.
Figure: 28 TAC §3.3830(d)

(e) Insurers using direct-response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy or certificate. The required notice shall be provided in the following manner.
Figure: 28 TAC §3.3830(e)

(f) When replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy or certificate shall be identified by the insurer, name of the insured, and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the replacing insurer at its home office, or the date the policy is issued, whichever is sooner.

(g) An application for a long-term care policy or certificate that contains benefits under §3.3818(b) of this subchapter (relating to Standards for Eligibility for Benefits) shall in equal prominence reflect the benefit levels payable for the inability to perform two activities of daily living, three activities of daily living, and cognitive impairment.

(h) Life Insurance policies with a long-term care rider that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the Insurance Code Chapter 1114 (relating to Replacement of Certain Life Insurance Policies and Annuities), Subchapter NN of this chapter (relating to Consumer Notices for Life Insurance Policy and Annuity Contract Replacements), and any additional rules adopted by the department pursuant to the Insurance Code Chapter 1114. If a life insurance policy with a long-term care rider that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

§3.3837. Reporting Requirements.

(a) Policy or Certificate Replacements and Lapses. The purpose of this subsection is to specify requirements for insurers issuing long-term care insurance benefits in this state to report to the commissioner information on a statewide basis regarding long-term care insurance policy or certificate replacements and lapses.

(1) Agent records.

(A) Each insurer shall maintain records, for each agent, of that agent's number and dollar amount of replacement sales as a percentage of the agent's total number and amount of annual sales attributable to long-term care products, as well as the number and dollar amount of lapses of long-term care insurance policies sold by the agent and expressed as a percentage of the agent's total annual sales attributable to long-term care products.

(B) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.

(2) Reporting of 10 percent of agents. Each insurer shall report by June 30 of every year the information indicated in the parts of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form on the listing of the 10 percent of agents data as specified in Figure: 28 TAC §3.3837(a)(2) for the 10 percent of its agents with the greatest percentages of policy or certificate lapses and replacements during the preceding calendar year. Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(a)(2)

(3) Reporting number of lapsed long-term care policies. Each insurer shall report by June 30 of every year the number of lapsed long-term care policies as a percentage of its total annual sales of such policies and as a percentage of its total number of long-term care policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(4) Reporting number of replacement long-term care policies. Each insurer shall report by June 30 of every year the number of

replacement long-term care policies sold as a percentage of its total annual sales of such products, and as a percentage of its total number of such policies in force during the preceding calendar year as indicated in the Company Totals part of Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form as specified in Figure: 28 TAC §3.3837(a)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(b) Rescissions. Each insurer issuing long-term care insurance benefits in this state shall maintain a record of all policy, contract, or certificate rescissions relating to such long-term care insurance benefits, both for coverage in this state and nationwide, except for those which the insured voluntarily effectuated, and shall report this data for the preceding calendar year to the commissioner by June 30 of every year as indicated on Form Number LHL563(LTC) Rescission Reporting Form for Long-Term Care Policies as specified in Figure: 28 TAC §3.3837(b). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(b)

(c) Claims Denied by Class of Business.

(1) Definitions. For purposes of this subsection, the following terms shall have the following meanings.

(A) Claim--A request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

(B) Denied--The insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

(2) Report of Claims Denied. Each insurer issuing long-term care insurance benefits in this state shall maintain a record by class of business of the number of long-term care claims for long-term care services denied during the preceding calendar year in this state. The insurer shall report the number of claims denied for each class of business expressed as a percentage of claims denied to the commissioner by June 30 of every year as indicated on Form Number LHL564(LTC) Long-Term Care Insurance Claim Denials Reporting Form as specified in Figure: 28 TAC §3.3837(c)(2). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(c)(2)

(d) Long-Term Care Partnership Program. Each insurer that markets partnership policies in this state shall report to the department by June 30 of each year the information required in §32.107 of the Human Resources Code, specifying the number of approved partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing approved partnership plans during the preceding calendar year in this state. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(e) Data Report for Non-Partnership Plans. Each insurer that markets long-term care insurance in this state shall report to the department by June 30 of each year the number of non-partnership plans sold in this state during the preceding calendar year and the average age of individuals purchasing such non-partnership plans. The information required in this subsection shall be reported in accordance with Form Number LHL565(LTC) Long-Term Care Policies Sold Reporting Form as specified in Figure: 28 TAC §3.3837(e). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.
Figure: 28 TAC §3.3837(e)

(f) Suitability Data. Each insurer issuing long-term care benefits in this state shall report suitability data for this state for the preceding calendar year to the commissioner by June 30 of each year as indicated on Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form as specified in Figure: 28 TAC §3.3837(f)(1). Each insurer shall submit the required information electronically in a format prescribed by the department on the department's website.

(1) Reporting Form. A representation of Form Number LHL566(LTC) Long-Term Care Suitability Reporting Form is as follows:
Figure: 28 TAC §3.3837(f)(1)

(2) Applicability.

(A) This subsection shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(B) This subsection shall not apply to life insurance policies:

(i) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(ii) that provide the option of a lump-sum payment for those benefits; and

(iii) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(g) Demonstration of compliance with applicable loss ratio standards. Each insurer shall file by June 30 of each year the annual rate filing required by the Insurance Code §1651.053(c) to demonstrate compliance with the applicable loss ratios of this state and any other filing requirement adopted by the commissioner relating to loss ratios. The filing must be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701. Such demonstration shall be in addition to any demonstration required under §3.3831(c)(2)(B) - (D) of this subchapter (relating to Standards and Rates) and shall include the following information by calendar duration, separately by form number:

(1) calendar duration;

(2) first year issued;

(3) actual earned premium by duration;

(4) actual incurred claims;

(5) actual calendar duration loss ratio;

(6) anticipated calendar duration loss ratio; and

(7) number of insured lives.

§3.3839. Standards for Marketing.

(a) Each insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its agents, shall establish and implement marketing procedures to assure that:

(1) any comparison of policies by its agents or other producers will be fair and accurate;

(2) excessive insurance is not sold or issued;

(3) every reasonable effort is made to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;

(4) no person shall, in selling or offering to sell a long-term care policy, misrepresent a material fact;

(5) the policy shall be delivered no later than 30 days after the application for the long-term care insurance policy or certificate is approved;

(6) the terms non-cancellable and level premium are used only to describe a policy or certificate that conforms to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability);

(7) auditable procedures are established to verify compliance with this subsection;

(8) at time of solicitation, the insurer provides written notice to the prospective policyholder and certificate holder that a senior insurance counseling program is available from the department and the name, address and telephone number of the program;

(9) at the time of application, an explanation is provided to the applicant of the contingent nonforfeiture benefit upon lapse provided for in §3.3844(g)(1) of this subchapter (relating to Nonforfeiture and Contingent Nonforfeiture Benefits) and, if applicable, an explanation of the additional contingent nonforfeiture benefit upon lapse provided for policies or certificates with fixed or limited premium payment periods as specified in §3.3844(g)(2) of this subchapter;

(10) at the time of application, copies of the disclosure forms (Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H) and Form Number LHL561(LTC) Long-Term Care Insurance Potential Rate Increase Disclosure Form as specified in Figure: 28 TAC §3.3829(b)(8)(I) are provided to the applicant; and

(11) the notice required in subparagraph (A) or (B) of this paragraph, as appropriate, is prominently displayed by type, stamp, or other appropriate means on the first page of both the policy (or certificate) and the outline of coverage.

(A) For any policy or certificate which contains inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations."

(B) For any policy or certificate which does not contain inflation protection provisions, the notice shall read as follows: "Notice to buyer: This policy (or certificate) may not cover all of the costs associated with long-term care incurred by the policyholder (or certificate holder) during the period of coverage. The policyholder (or certificate holder) is advised to review carefully all policy limitations. In addition, the policyholder (or certificate holder) is advised that based on current health care cost trends, the benefits provided by this policy (or certificate) may be significantly diminished in terms of real value to the policyholder (or certificate holder), depending on the amount of time which elapses between the date of purchase and the date upon which the policyholder (or certificate holder) first becomes eligible for those benefits."

(b) The marketing of a long-term care insurance policy or certificate which includes benefits provisions under §3.3818(b) of this subchapter (relating to Standards for Eligibility for Benefits) shall disclose within a common location and in equal prominence a description of all benefit levels payable for coverage described in §3.3818(b) of this subchapter.

(c) In addition to the practices prohibited in the Insurance Code Chapter 541, the following acts and practices are unfair methods of competition or unfair or deceptive acts or practices in the marketing of long-term care policies or certificates in this state and are prohibited under §541.003 of the Insurance Code.

(1) Twisting--Knowingly making any misleading representation or incomplete or fraudulent comparisons of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics--Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising--Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(4) Misrepresentation--Selling, marketing, offering, or advertising any insurance policy, certificate, or rider to such policy or certificate, which substantially meets the definition of long-term care insurance found in the Insurance Code §1651.003, but which provides benefits for a period of fewer than 12 months.

§3.3842. Appropriateness of Recommended Purchase.

(a) In recommending the purchase or replacement of any long-term care insurance policy or certificate, the company and the agent shall make reasonable efforts to determine the appropriateness of the recommended purchase or replacement.

(b) Each insurer, health care service plan, or other entity marketing long-term care insurance (issuer) shall:

(1) develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(2) train its agents in the use of its suitability standards; and

(3) maintain a copy of its suitability standards and make them available for inspection upon request by the commissioner.

(c) To determine whether the applicant meets the standards developed by the issuer, the agent and issuer shall develop procedures that take the following factors into consideration:

(1) the applicant's ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

(2) the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

(3) the values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(d) The issuer and, where an agent is involved, the agent, shall make reasonable efforts to obtain the information set forth in subsection (c) of this section. The efforts shall include presentation to the applicant, at or prior to application, the Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet as specified in Figure: 28 TAC §3.3829(b)(8)(H). The issuer may request the applicant to provide additional information to comply with the issuer's suitability standards. The following requirements apply if the issuer requests such additional information on the personal worksheet:

(1) A copy of the issuer's Long-Term Care Insurance Personal Worksheet Form Number LHL560(LTC) that includes the additional information that is requested to comply with the issuer's suitability standards must be filed with the department for approval prior to use.

(2) Any form filed pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(3) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(e) The issuer must receive the completed personal worksheet from the applicant prior to the issuer's consideration of the applicant for coverage, except the completed personal worksheet does not need to be received by the issuer prior to the issuer's consideration of an applicant for coverage for employer group long-term care insurance for employees and their spouses.

(f) The sale or dissemination outside of the company or agency by the issuer or agent of information obtained through the completion of Form Number LHL560(LTC) Long-Term Care Insurance Personal Worksheet, including any additional information provided to comply with the issuer's suitability standards, is prohibited.

(g) The issuer shall use the suitability standards that it has developed pursuant to this section in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(h) Agents must use the suitability standards developed by the issuer in marketing the issuer's long-term care insurance.

(i) At the same time that the personal worksheet is provided to the applicant, Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance, containing the text specified in Figure: 28 TAC §3.3842(i)(7) must also be provided to the applicant. The following requirements and procedures apply to this form:

(1) The text must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3842(i)(7).

(2) The text as specified in Figure: 28 TAC §3.3842(i)(7) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3842(i)(7) if the insurer files the form for review and approval by the commissioner.

(3) The form must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) An insurer may add a company name and identifying form number to Form Number LHL567(LTC) as specified in Figure: 28 TAC §3.3842(i)(7) without obtaining commissioner approval.

(5) The Instructions to Company that are included in Figure: 28 TAC §3.3842(i)(7) are to aid the insurer in drafting the form and should not be included in the text of the form used by the insurer.

(6) If filing the form for review and approval as provided under paragraphs (2) and (3) of this subsection, the insurer must file the form with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(7) A representation of Form Number LHL567(LTC) Things You Should Know Before You Buy Long-Term Care Insurance is as follows:
Figure: 28 TAC §3.3842(i)(7)

(j) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide all of the requested information, the issuer may reject the application or the issuer must send the applicant a letter in accordance with or similar to Form Number LHL568(LTC) Long-Term Care Insurance Suitability Letter. However, only in the event that the applicant has declined to provide the requested financial information, the issuer may use some other method to verify the applicant's intent. This method, at the option of the issuer, may include phone call, fax, U.S. mail, email or any combination of these methods. Either the applicant's returned Suitability Letter containing the applicant's response or a record of the alternative method of verification must be made a part of the applicant's file. If the issuer elects to send the applicant a Suitability Letter to comply with the requirements of this subsection, the following specifies the Suitability Letter and the requirements and procedures that apply:
Figure: 28 TAC §3.3842(j)

(1) The issuer's Suitability Letter must use the text in Form Number LHL568(LTC) as specified in Figure: 28 TAC §3.3842(j) or be similar to the text specified in Figure: 28 TAC §3.3842(j).

(2) The text must be in at least 12-point type.

(3) The Instructions to Company that are included in Figure: 28 TAC §3.3842(j) are to aid the issuer in drafting the form and should not be included in the text of the letter sent to the applicant.

(4) The form number should not be included on the letter sent to the applicant.

(k) This section and the delivery requirements for the shopper's guide in §3.3840 of this subchapter (relating to Requirements to Deliver Shopper's Guide) shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(l) This section and the delivery requirements for the shopper's guide in §3.3840 of this subchapter shall not apply to life insurance policies:

(1) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(2) that provide the option of a lump-sum payment for those benefits; and

(3) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3844. Nonforfeiture and Contingent Nonforfeiture Benefits.

(a) Required Offering of Nonforfeiture Benefits and Contingent Benefits upon Lapse. No insurer or other entity may offer a long-term care insurance policy or certificate in this state unless such insurer or other entity also offers to the prospective insured, or to the

group policyholder, the option to purchase a policy that contains nonforfeiture benefits. On or after July 1, 2002, in the event a policyholder or certificate holder declines the option to purchase a policy that contains nonforfeiture benefits, the insurer shall provide contingent benefits upon lapse as described in subsection (g) of this section. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(b) Nonforfeiture Benefit Provisions.

(1) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums. The amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.

(2) The nonforfeiture provision shall be clearly and conspicuously captioned.

(c) Nonforfeiture Benefit Options. Insurers shall offer at least one of the following nonforfeiture options:

(1) reduced paid-up;

(2) extended term;

(3) shortened benefit period; or

(4) other offerings approved by the U.S. Secretary of Health and Human Services as provided by the Internal Revenue Code §7702B(g)(4)(B).

(d) Nonforfeiture and Contingent Benefit Standards/Requirements.

(1) Except as provided in paragraph (2) of this subsection, no policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(3) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(4) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(5) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(6) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the requirements of §3.3831 of this subchapter (relating to Standards and Rates) treating the policy as a whole.

(7) To determine whether the contingent nonforfeiture upon lapse provisions are triggered, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(8) A qualified actuary shall certify as to the reasonability of rates charged for each nonforfeiture benefit and the reserving required by §3.3819 of this subchapter (relating to Requirement for Reserve) shall include reserving for the nonforfeiture options.

(e) Benefits Continued as Nonforfeiture Benefits. This subsection applies to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(1) of this section but does not apply to contingent nonforfeiture benefits upon lapse in accordance with subsection (g)(2) of this section:

(1) The shortened benefit period shall provide paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (2) of this subsection.

(2) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limits specified in the policy or certificate.

(3) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50 and at least three percent per year beyond age 50.

(f) Disclosure of Nonforfeiture Benefits. The application or a separate form shall include an election to accept or reject the nonforfeiture benefit. The rejection notice shall state: "I have reviewed the outline of coverage and the explanation of nonforfeiture benefits and I reject the nonforfeiture option." The agent shall provide information to assist the prospective policyholder in accurately completing the rejection statement.

(g) Contingent Nonforfeiture Benefits.

(1) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Triggers for a Substantial Premium Increase based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase. Figure: 28 TAC §3.3844(g)(1)

(2) A contingent nonforfeiture benefit on lapse shall also be triggered for policies or certificates with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Figure: 28 TAC §3.3844(g)(2) based on the insured's issue age, the policy or certificate lapses after notice of the rate increase is issued and within 120 days before or after notice of the due date of the premium so increased, and the ratio in paragraph (4)(B) of this subsection is 40 percent or more. Unless otherwise required, policyholders must be notified at least 45 days prior to the due date of the premium reflecting the rate increase. The provision of this paragraph shall be in

addition to the contingent nonforfeiture benefit provided by paragraph (1) of this subsection and where both are triggered, the benefit provided shall be at the option of the insured.
Figure: 28 TAC §3.3844(g)(2)

(3) On or after the effective date of a substantial premium increase as set forth in paragraph (1) of this subsection, the insurer shall:

(A) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (e) of this section. This option may be elected at any time during the 120-day period referenced in paragraph (1) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (1) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph.

(4) On or before the effective date of a substantial premium increase as defined in paragraph (2) of this subsection, the insurer shall:

(A) offer to reduce policy or certificate benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) offer to convert the coverage to a paid-up status where the amount payable for each benefit is 90 percent of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in paragraph (2) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (2) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph if the ratio is 40 percent or more.

(h) Applicability.

(1) This section shall apply to riders for group and individual annuities and life insurance policies that provide long-term care insurance.

(2) This section shall not apply to life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(B) that provide the option of a lump-sum payment for those benefits; and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3848. Requirements for Limited Premium Payment Options in Long-Term Care Policies, Certificates, and Riders.

(a) Definition and Applicability. Long-term care policies, certificates, and riders with limited premium payment options limit premium payments to a single payment or to a stated number of years not to exceed 10 years. Limited premium payment policies, certificates, and riders must comply with this subchapter, Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings), and the additional requirements specified in subsection (b) of this section. Any policy, certificate or rider that contains a paid-up option at a specified age and becomes paid up in 10 years or less is subject to this section. Nothing in this section prohibits a carrier from offering premium payment duration options in excess of 10 years, and any such options are not subject to this section.

(b) Requirements.

(1) Notice. A long-term care insurance policy or certificate with a limited premium payment option must accurately reflect a plan with a limited premium payment option.

(2) Minimum Standards. The provisions in long-term care policies, certificates, and riders with limited premium payment options must be at least as favorable as the requirements and provisions specified in this section.

(3) Single-Premium Payment Option. A single-premium payment option policy, certificate, or rider must be noncancellable as provided in §3.3810(a) of this subchapter (relating to Policy or Certificate Standards for Noncancellability). The renewability provision on the face page of the policy or certificate must conform with the following: "NONCANCELLATION PROVISION: This policy provides that premiums are paid by a single premium after which no additional premiums are due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(4) One-to-Four Year Premium Payment Options. A long-term care policy, certificate, or rider with a one-to-four year premium payment option must be noncancellable as provided in §3.3810(a) of this subchapter. The renewability provision on the face page of a policy or certificate must conform with the following: "NONCANCELLATION PROVISION: This policy provides that your premiums may be paid over a period of [n] (n may equal 1, 2, 3, or 4) years, after which no additional premiums will be due and your policy is fully paid up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(5) Five-to-Ten Year Premium Payment Options. A long-term care policy, certificate or rider with a five-to-ten year premium payment option must be guaranteed renewable as provided in §3.3807(a) of this subchapter (relating to Policy or Certificate Standards for Guaranteed Renewability) and must comply with the following requirements:

(A) The renewability provision on the face page of a long-term care policy or certificate must conform to the following: "This policy provides that your premiums be paid over a period of [n] (n may equal 5, 6, 7, 8, 9 or 10) years, after which no additional premiums will be due and your policy is fully paid-up and noncancellable. We cannot cancel your policy and we cannot make any changes unless requested by you, subject to the maximum benefits under the policy." In the alternative, the required renewability provision may be added to the policy via an endorsement and change to the schedule page.

(B) A provision must be included in the policy, certificate or rider that provides for a return of premium upon cancellation, as described in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(C) Each long-term care policy, certificate or rider must be accompanied by the disclosure specified in clause (i) of this subparagraph and the Return of Premium chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii).

(i) Disclosure. The return of premium provision must conform with the following: "RETURN OF PREMIUM: Upon cancellation of this policy by you during the premium-paying period, we will return a portion of the total premiums paid less any benefits paid under the policy. The portion of the total premium paid will be determined in accordance with the accompanying chart, labeled Return of Premium Schedule."

(ii) Return of Premium Schedule. The return of Premium Schedule chart, which specifies the percentage of premium that the insurer is required to return to the insured expressed as a function of the premium payment option (5, 6, 7, 8, 9, and 10 year premium payment options) and of the number of completed years prior to the policy, certificate or rider being canceled, must comply with the following requirements:

Figure: 28 TAC §3.3848(b)(5)(C)(ii)

(I) The chart must be in not less than 12-point bold type.

(II) The chart must conform to the representation in Figure: 28 TAC §3.3848(b)(5)(C)(ii), and must be labeled "Return of Premium Schedule."

(iii) Under no circumstances shall the application of Figure: 28 TAC §3.3848(b)(5)(C)(ii) result in an amount that exceeds the aggregate premiums paid under the contract, when combined with any other provision of this chapter.

(D) Using the Return of Premium Chart specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), the return of premium amount must be at least as great as the sum of clause (i) plus clause (ii) minus clause (iii) of this subparagraph:

(i) [(I) - (II)] X (III), where (I), (II) and (III) are as follows:

(I) the cumulative premium paid under the limited premium payment option specified in the policy, certificate, or rider;

(II) the cumulative premium that would have been paid under a lifetime premium payment option;

(III) the percentage specified in Figure: 28 TAC §3.3848(b)(5)(C)(ii), corresponding to the number of completed policy years and limited premium payment period specified in the policy, certificate, or rider;

(ii) the pro-rata unearned premium based on the premium paid for the year of cancellation;

(iii) any benefits paid under the policy.

(E) An example of the calculation of the return of premium required under this section is as follows:

(i) Given the facts provided in subclauses (I), (II), (III), and (IV) of this clause as follows:

(I) policy, certificate, or rider issue date: January 1, 2006;

(II) date of cancellation: April 1, 2008;

(III) 10-pay annual premium: $10,000;

(IV) annual lifetime premium: $1,000;

(ii) Portion of return of premium calculated under subparagraph (D)(i) of this paragraph is equal to .05 X [($10,000 + $10,000) - ($1,000 + $1,000)] = .05 X ($20,000 - $2,000) = .05 X $18,000 = $900;

(iii) Portion of return of premium calculated under subparagraph (D)(ii) of this paragraph is equal to $10,000 X 9/12 = $7,500;

(iv) Total return of premium due is equal to $900 + $7,500 = $8,400 less any benefits paid under the policy.

§3.3849. Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies.

(a) Insurer Requirements.

(1) Any insurer issuing long-term care insurance to an association, as defined in the Insurance Code §1251.052, shall file with the department in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) the following:

(A) the long-term care policy and certificate;

(B) a corresponding outline of coverage; and

(C) annual certification of the association's compliance with marketing standards for long-term care policies and certificates in accordance with Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in Figure: 28 TAC §3.3849(e)(1)(F).

(2) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the department the information required in this subsection.

(b) Advertisements. Advertisements for long-term care insurance must be filed with the department in accordance with §3.3838(1) of this subchapter (relating to Filing Requirements for Advertising).

(c) Association Disclosure Requirements.

(1) An association must disclose in any long-term care insurance solicitation to its members:

(A) the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

(B) a brief description of the process under which the policies and the insurer issuing the policies were selected.

(2) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(d) Board Approval Requirements. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies and certificates as well as the compensation arrangements made with the insurer.

(e) Insurer Certification Form.

(1) The following requirements and procedures apply to Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form specified in Figure: 28 TAC §3.3849(e)(1)(F):

(A) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3849(e)(1)(F).

(B) The text of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form as specified in Figure: 28 TAC §3.3849(e)(1)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3849(e)(1)(F) if the insurer files the reformatted certification form for review and approval by the commissioner.

(C) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL573(LTC) Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates Form is as follows:
Figure: 28 TAC §3.3849(e)(1)(F)

(2) The initial certification shall be submitted to the department between January 1, 2010 and January 31, 2010, for the calendar year 2009, and thereafter shall be submitted annually between January 1 and January 31 for the preceding calendar year.

(3) Form Number LHL573(LTC) is an informational filing pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The annual completed certification form submitted pursuant to paragraphs (2) and (3) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2009.

TRD-200900160
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: February 2, 2009
Proposal publication date: July 18, 2008
For further information, please call: (512) 463-6327

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DIVISION 3. NON-PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

28 TAC §3.3860

STATUTORY AUTHORITY. The new section is adopted pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and 36.001; and §1917(b) of the Social Security Act as amended by §6021 of the Deficit Reduction Act of 2005 (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. Senate Bill (SB) 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter 1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Texas Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare

Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code; (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act; (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership; (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA; and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

§3.3860. Policy Summary Requirements for Non-Partnership Life Insurance Policies and Annuity Contracts that Provide Long-Term Care Benefits.

(a) At the time of delivery of a non-partnership life insurance policy or annuity contract that provides long-term care benefits by rider, a policy summary shall be delivered. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make delivery no later than at the time of policy delivery. The policy summary must comply with all applicable requirements of this section and must include:

(1) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

(3) any exclusions, reductions and limitations on benefits of long-term care;

(4) a statement that any long-term care inflation protection option required by §3.3820 of this subchapter (relating to Requirement to Offer Inflation Protection) and §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) is not available under this policy;

(5) if applicable to the policy type:

(A) a disclosure of the effects of exercising other rights under the policy;

(B) a disclosure of guarantees related to long-term care costs of insurance charges; and

(C) a disclosure of current and projected maximum lifetime benefits.

(b) The provisions of the policy summary required in subsection (a) of this section may be incorporated into a basic illustration that is required to be delivered in accordance with Chapter 21, Subchapter N of this title (relating to Life Insurance Illustrations).

(c) During the entire time that a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(1) any long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and

(3) the amount of long-term care benefits existing or remaining.

(d) The statement required in subsection (a)(4) of this section applies to:

(1) riders for group and individual annuities and life insurance policies that provide long-term care insurance;

(2) life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(B) that provide the option of a lump-sum payment for those benefits; and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 13, 2009.

TRD-200900161
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: February 2, 2009
Proposal publication date: July 18, 2008
For further information, please call: (512) 463-6327

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DIVISION 4. PARTNERSHIP LONG-TERM CARE INSURANCE ONLY

28 TAC §§3.3870 - 3.3874

STATUTORY AUTHORITY. The new sections are adopted pursuant to the Insurance Code §§1651.004, 1651.101 - 1651.107, and 36.001; and §1917(b) of the Social Security Act as amended by §6021 of the Deficit Reduction Act of 2005 (pertaining to Expansion of State Long-Term Care Partnership Program) (42 U.S.C. §1396p(b)). Section 1651.004 provides that the Department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651 concerning long-term care benefit plans. Senate Bill (SB) 22 enacted by the 80th Legislature, Regular Session, effective March 1, 2008, amended Chapter

1651 to add new Subchapter C concerning the Partnership for Long-Term Care Program. Section 1651.101 specifies the definitions that are specific to the Texas partnership program. Section 1651.102 specifies the applicability of Subchapters A (General Provisions) and B (Benefit Plan Standards), which were in effect prior to the enactment of SB 22, to the partnership policies issued in accordance with new Subchapter C. Section 1651.103 requires that the Department assist the Texas Health and Human Services Commission as necessary for the Commission to perform its statutorily specified partnership program duties and functions, as provided in Chapter 32 Subchapter C. of the Human Resources Code. Section 1651.104 requires the Department to adopt, in consultation with the Texas Health and Human Services Commission, minimum standards for a long-term care benefit plan that qualifies as an approved plan under the partnership program and further requires that the standards be consistent with the provisions of the federal DRA. Section 1651.105 requires that each individual who sells a partnership policy must complete training and demonstrate an understanding of how partnership policies relate to other public and private coverage of long-term care and requires each insurer that offers partnership policies to certify to the Commissioner that its agents who sell partnership policies comply with the required training requirements. Section 1651.106 provides that, if the partnership program is discontinued, an individual who has purchased a partnership policy remains eligible to receive the benefits under the partnership policy. Section 1651.107 authorizes the Commissioner to adopt rules as necessary to implement Subchapter C. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

The federal enabling legislation regulating qualified partnerships was enacted in the DRA of 2005; it was signed into law on February 8, 2006. Section 6021(a)(1)(A) of the DRA expands State Long-Term Care Partnership Programs, which encourage individuals to purchase long-term care insurance. State partnership programs are intended to promote consumers' purchase of long-term care insurance from private insurers by providing consumers with access to Medicaid under special eligibility rules in the event that an individual consumer should ever need Medicaid long-term care coverage that is in addition to that provided by the purchased partnership coverage. The DRA amends §1917(b)(1)(C) of the Social Security Act by adding new clause (iii) to permit states to exempt long-term care benefits from estate recovery, if the state has a state plan amendment filed with and approved by the Department of Health and Human Services Center for Medicaid and Medicare Services that provides for a qualified state long-term care insurance partnership. Additionally, §6021(a)(1)(A) of the DRA enacts several new provisions codified at §1917(b)(1)(C) of the Social Security Act that specify the requirements for partnership policies, including: (i) §1917(b)(1)(C)(iii)(II) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(II)) specifies that the policy must be a qualified long-term care insurance contract as defined in §7702B(b) of the Internal Revenue Code; (ii) §1917(b)(1)(C)(iii)(III) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(III)) specifies that the policy must meet the consumer protection requirements in §1917(b)(5)(A) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(5)(A)) which include meeting the requirements of specific portions of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulations and Model Act; (iii) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must be issued not earlier than the effective date of the Qualified Partnership; (iv) §1917(b)(1)(C)(iii)(IV) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)) specifies that the policy must include inflation protection in accordance with the DRA; and (v) §1917(b)(1)(C)(iii)(I) of the Social Security Act as amended by the Deficit Reduction Act (42 U.S.C. §1396p(b)(1)(C)(iii)(I)) specifies that the policy must cover an insured who is a resident of the state when the coverage first became effective.

§3.3870. Exchange Requirements for Long-Term Care Partnership Policies.

(a) Notification and Offer of Exchange. Within 18 months from the date that an insurer begins to advertise, market, offer, or sell, policies under the Texas Long-Term Care Partnership Program the insurer is required to offer on a one-time basis, in writing, to all policyholders or certificate holders that were issued long-term care coverage of the type certified by the insurer on or after February 8, 2006, the option to exchange their existing policy or certificate for a partnership policy or certificate.

(b) New Coverage. The insurer shall make the new coverage available in one of the following ways:

(1) by adding a rider or endorsement to the existing policy and charging a separate premium for the new rider or endorsement based on the insured's attained age if an additional premium is appropriate; or

(2) by exchanging the existing policy or certificate for a new partnership policy or certificate.

(A) If the new coverage has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing coverage, based on uniform assumptions as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the new policy shall not be underwritten; and

(ii) the rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.

(B) If the new coverage has an actuarial value of benefits exceeding the actuarial value of benefits of the existing coverage, based on uniform assumptions, as determined on the date of issue for a new insured, then the following two requirements apply:

(i) the insurer shall apply its new business, long-term care underwriting guidelines to the increased benefits only; and

(ii) the rate charged for the new policy shall be determined using the method set forth in subparagraph (A)(ii) of this paragraph for the existing benefits, increased by the rate for the increased benefits using the current attained age and risk class of the insured for the increased benefits only.

(C) In lieu of subparagraphs (A) and (B) of this paragraph, an insurer may implement an alternative exchange methodology or program only for policies or certificates issued on and after February 8, 2006, and that is filed with the department and approved by the commissioner in accordance with the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(c) Exchange Requirements. Any exchange of an existing long-term care policy or certificate for a partnership policy or certificate must comply with the following requirements:

(1) Any offer of exchange shall be made to all policyholders on a nondiscriminatory basis.

(2) An exchange offer shall be deferred to all policyholders who are currently eligible for benefits, within an elimination period on a claim, or who would not be eligible to apply for coverage due to issue age limitations under the new policy, until such time when such condition expires.

(3) All rates for exchanges must meet the requirements specified in §3.3831 of this subchapter (relating to Standards and Rates). In accordance with §3.3831 of this subchapter, exchange policies may be underwritten, and the premium may be increased, subject to §3.3810 of this subchapter (relating to Policy or Certificate Standards for Noncancellability).

(4) The new coverage offered shall be on a form that is currently approved for sale in the general market.

(5) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that have accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.

(d) Exchanges and Not Replacements. Policies issued pursuant to this section shall be considered exchanges and not replacements.

(e) One-time Reporting Requirement. An insurer is required to report exchanges made pursuant to this section on a one-time basis for the reporting period in which the insurer begins to advertise, market, offer, or sell policies under the Texas Long-Term Care Partnership Program on Form Number LHL562(LTC) Long-Term Care Insurance Replacement and Lapse Reporting Form in accordance with the procedures and requirements specified in §3.3837(a)(4) of this subchapter (relating to Reporting Requirements).

§3.3871. Standards and Reporting Requirements for Approved Long-Term Care Partnership Policies and Certificates.

(a) Standards.

(1) General requirements. In addition to the required filing and approval pursuant to §3.3873 of this subchapter (relating to Filing Requirements for Long-Term Care Partnership Policies), any policy or certificate marketed or represented to qualify as a long-term care partnership policy or certificate must comply with the following requirements:

(A) the insured individual was a resident of Texas when coverage first became effective under the policy. If the policy or certificate is later exchanged for a different long-term care policy or certificate, the individual was a resident of Texas when coverage under the first policy became effective;

(B) the policy is intended to be a qualified long-term care insurance policy under the provisions of §3.3847 of this subchapter (relating to Qualified Long-Term Care Insurance Contracts; Prohibited Representations);

(C) the policy or certificate is issued with and retains inflation coverage that meets the inflation standards specified in §3.3872 of this subchapter (relating to Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates) based on the insured's then attained age;

(D) the effective date of the newly issued partnership policy, which is shown on the policy schedule page, must be either the date that the partnership policy is issued or the date the application for the partnership policy was signed. The insurer has the option of using either date, but the insurer must use the same option in all partnership policies issued by that insurer.

(2) Required disclosure notice.

(A) A policy or certificate represented or marketed as a long-term care partnership policy or certificate shall be accompanied by a disclosure notice that explains the benefits associated with the policy or certificate. The required disclosure notice is set forth in Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(B) The following requirements and procedures apply to Form Number LHL569(LTC):

(i) The text in the notice must be in at least 12-point type and must follow the order of the information presented in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ii) The text in the notice as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) if the insurer files the form for review and approval by the commissioner.

(iii) Any form filed pursuant to clause (ii) of this subparagraph must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(iv) An insurer may add a company name and identifying form number to Form Number LHL569(LTC) as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii) without obtaining commissioner approval.

(v) The Instructions to Company that are included in Figure: 28 TAC §3.3871(a)(2)(B)(vii) are to aid the insurer in drafting the form and should not be included in the disclosure notice provided by the insurer.

(vi) Any form filed pursuant to clause (ii) of this subparagraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(vii) A representation of Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates is as follows:
Figure: 28 TAC §3.3871(a)(2)(B)(vii)

(viii) Any policyholder that exchanges their policy for a partnership policy must be provided with the required Form Number LHL569(LTC) Partnership Status Disclosure Notice for Long-Term Care Partnership Policies/Certificates as specified in Figure: 28 TAC §3.3871(a)(2)(B)(vii).

(ix) When an insurer is made aware that a policyholder or certificate holder has initiated action that will result in the loss of partnership status, the insurer must provide an explanation of how such action impacts the insured in writing. The insurer must also advise the policyholder or certificate holder on how to retain partnership status if possible.

(x) If a partnership plan subsequently loses partnership status, the insurer must explain to the policyholders or certificate holders in writing the reason for the loss of status.

(3) Commissioner certification. Under §1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. §1396p(b)(5)(B)(iii)), the Commissioner of Insurance, in implementing the Texas Long-Term Care Partnership Insurance Program ("Partnership Program"), may certify that long-term care insurance policies and certificates covered under the Partnership Program meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in §1917(b)(5)(A) of the Social Security Act and principally include certain specified provisions of the NAIC Long-Term Care Model Act and Model Regulations (adopted as of October 2000). In providing this certification, the commissioner may reasonably rely upon the certification by insurers of the policy forms that is made in accordance Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in Figure: 28 TAC §3.3873(a)(2)(F).

(b) Reporting Requirements. In accordance with §1917(b)(1)(C)(iii)(VI) and (v) of the Social Security Act, all issuers of partnership policies or certificates shall provide regular reports to the Secretary of the Department of Health and Human Services (Secretary) in accordance with regulations to be developed by the Secretary. Such information shall include but not be limited to the following:

(1) notification regarding when insurance benefits provided under partnership policies or certificates have been paid and the amount of such benefits paid;

(2) notification regarding when such policies or certificates otherwise terminate; and

(3) any other information the Secretary determines is appropriate.

§3.3872. Inflation Protection Requirements for Long-Term Care Partnership Policies and Certificates.

(a) Pursuant to §1917(b)(1)(C)(iii)(IV) of the Social Security Act (42 U.S.C. §1396p(b)(1)(C)(iii)(IV)), an insurer shall not issue a policy or certificate marketed or represented to qualify as an approved long-term care partnership policy unless the policy or certificate complies with the following inflation protection requirements:

(1) For a person who is less than 61 years of age, as of the date of purchase, the policy or certificate must provide compound annual inflation protection from the date of purchase until the person attains 61 years of age.

(A) At the time of purchase, insurers must offer to each applicant the option to purchase compound annual inflation protection that automatically increases each year on a compounded basis at a rate of not less than 5.0 percent annually throughout the interval of coverage. The inflation protection is required to automatically increase benefits each year on a compounded basis.

(B) If the applicant declines the offer of inflation protection specified in subparagraph (A) of this paragraph, then the insurer must offer and the applicant must purchase and retain compound annual inflation protection until the insured attains age 61 or goes on claim status, whichever comes first. The inflation protection is required to automatically increase benefits each year on a compounded basis at a rate that the insured elects which may be in a range of from one percent to four percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(C) A person who is less than 61 years of age that has purchased a long-term care partnership policy or certificate with the required compound inflation protection specified in this paragraph may upon attaining 61 years of age choose to amend the compound inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (2) of this subsection.

(2) For a person who is at least 61 years of age but less than 76 years of age, the policy or certificate must provide an acceptable level of inflation protection until the person attains 76 of years age. Acceptable inflation protection includes the following:

(A) Regardless of the insured's health status, the insurer must offer and the insured must purchase and retain inflation protection until the insured attains age 76 or goes on claim status, whichever comes first.

(B) Acceptable coverage includes automatic annual inflation protection, either simple or compound, paid with either level or stepped premium.

(C) Inflation protection as required by this paragraph may be in a range of from one percent to five percent or tied to the Consumer Price Index for All Urban Consumers (CPI-U).

(D) A person who is less than 76 years of age that has purchased a long-term care partnership policy or certificate with the required inflation protection specified in this paragraph may upon attaining 76 years of age choose to amend the inflation protection provision in the policy or certificate in accordance with the requirements specified in paragraph (3) of this subsection.

(3) For any person who has attained the age of 76, inflation protection may be provided but is not required. However, the long-term care inflation protection option specified in §3.3820 of this subchapter (relating to Requirement To Offer Inflation Protection) must be offered to any applicant for a partnership policy who has attained the age of 76.

(4) An option to purchase inflation protection at a future time does not constitute compliance with the inflation protection requirements set forth in paragraphs (1) and (2) of this subsection.

(b) The inflation protection provisions in this section are not available under these policies:

(1) riders for group and individual annuities and life insurance policies that provide long-term care insurance;

(2) life insurance policies:

(A) that accelerate the death benefit for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement; and

(B) that provide the option of a lump-sum payment for those benefits; and

(C) where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

§3.3873. Filing Requirements for Long-Term Care Partnership Policies.

(a) Prior Approval Requirements. Each long-term partnership policy or certificate, including any long-term care partnership endorsement, that is to be delivered or issued for delivery in this state must comply with the requirements specified in paragraphs (1) and (2) of this subsection before being delivered or issued in this state.

(1) Each long-term care partnership policy, certificate, or endorsement must be filed with the department and approved by the commissioner in accordance with the requirements and procedures set

forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings) and subsections (b) and (c) of this section, as applicable.

(2) Each long-term care partnership policy, certificate, or endorsement filing must include Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form, as specified in Figure: 28 TAC §3.3873(a)(2)(F). The following requirements and procedures apply to this certification form:

(A) The text in the certification form must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3873(a)(2)(F).

(B) The text in the certification form as specified in Figure: 28 TAC §3.3873(a)(2)(F) is mandated; the format for the form is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3873(a)(2)(F) if the insurer files the certification form for review and approval by the commissioner.

(C) Any certification form that is filed for approval pursuant to subparagraph (B) of this paragraph must be filed no later than 60 days prior to use in any filing of a policy, certificate or endorsement submitted pursuant to subsection (c) or (d) of this section and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(D) Any certification form filed pursuant to subparagraph (B) of this paragraph should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(E) Form Number LHL570(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(F) A representation of Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form is as follows:
Figure: 28 TAC §3.3873(a)(2)(F)

(b) Policies Not Previously Approved. Any policy or certificate, including any endorsement, that has not been previously approved by the commissioner must comply with the requirements specified in paragraphs (1) - (4) of this subsection prior to an insurer offering the policy for sale in Texas as a partnership policy:

(1) The policy, certificate, or endorsement must be filed with the department and approved by the commissioner, and Form Number LHL570(LTC) as specified in subsection (a)(2)(F) of this section must be filed for each policy, certificate, or endorsement form submitted for partnership policy approval.

(2) The policy, certificate, or endorsement form must be in at least 10-point type.

(3) Any filing made pursuant to paragraph (1) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(4) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

(c) Previously Approved Policies. Insurers requesting to use a previously approved non-partnership policy form as a long-term care partnership policy must comply with the requirements specified in paragraphs (1)- (6) of this subsection prior to offering the policy for sale in Texas as a partnership policy:

(1) The insurer must file Form Number LHL570(LTC) Long-Term Care Partnership Program Insurer Certification Form as specified in subsection (a)(2)(F) of this section and must include a copy of any endorsement that is needed to comply with partnership policy requirements.

(2) The policy form number(s) or other identifying information, such as certificate series, must be provided on Form Number LHL570(LTC) as a part of the filing.

(3) The filing must be approved by the commissioner prior to an insurer offering the policy for sale in Texas as a partnership policy.

(4) The policy or certificate does not have to be included in the filing if it has been previously filed and approved by the commissioner.

(5) Any filing made pursuant to this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter.

(6) The filing should be submitted to the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

§3.3874. Insurer Requirements for Agents That Market Partnership Policies and Certificates.

(a) Insurer Training Verification and Certification Requirements for Agents. The following requirements apply to an insurer that is offering partnership policies or certificates in this state.

(1) The insurer is required to obtain verification that an agent has received the training specified in §19.1022 of this title (relating to Long-Term Care Partnership Certification Course).

(2) Pursuant to the Insurance Code §1651.105(b), the insurer is required to certify to the commissioner that each agent who sells partnership policies or certificates on behalf of the insurer complies with the training requirements of this subsection. The initial certification must be submitted on Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A). Any subsequent certification must be submitted on Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B).

(3) The insurer is required to maintain records of the verification required in paragraph (1) of this subsection for at least four years from the date the verification is received, and the department or its designee may review these records at any time.

(b) Agent Training Certification Form Requirements. The following requirements and procedures apply to Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form as specified in Figure: 28 TAC §3.3874(b)(6)(A) and Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, as specified in Figure: 28 TAC §3.3874(b)(6)(B):

(1) The text must be in at least 10-point type and must follow the order of the information presented in Figure: 28 TAC §3.3874(b)(6)(A) and in Figure: 28 TAC §3.3874(b)(6)(B).

(2) The text of Form Number LHL571(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(A) and the text of Form Number LHL572(LTC) as specified in Figure: 28 TAC §3.3874(b)(6)(B) are mandated; the format for the forms is a recommended format. An insurer may format the mandated text in a different format from that specified in Figure: 28 TAC §3.3874(b)(6)(A) and Figure: 28 TAC §3.3874(b)(6)(B) if the insurer files the reformatted certification form for review and approval by the commissioner.

(3) Any reformatted certification form that is filed for approval pursuant to paragraph (2) of this subsection must be filed no later than 60 days prior to use and is subject to the requirements and procedures set forth in Subchapter A of this chapter (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(4) Any reformatted certification form filed pursuant to paragraph (2) of this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104 or 333 Guadalupe, Austin, Texas 78701.

(5) Form Number LHL571(LTC) and Form Number LHL572(LTC) may be obtained from the Life/Health Division, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or from the department's website at www.tdi.state.tx.us.

(6) Representations of Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form and Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form are specified in subparagraphs (A) and (B) of this paragraph.

(A) A representation of Form Number LHL571(LTC) is as follows:
Figure: 28 TAC §3.3874(b)(6)(A)

(B) A representation of Form Number LHL572(LTC) is as follows:
Figure: 28 TAC §3.3874(b)(6)(B)

(c) Agent Training Certification Filing Requirements. An insurer offering partnership policies or certificates in this state shall submit for the initial certification to the department Form Number LHL571(LTC) Long-Term Care Partnership Agent Training Certification Initial Reporting Form containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(A) and shall submit for the subsequent annual certifications to the department Form Number LHL572(LTC) Long-Term Care Partnership Agent Training Certification Form, containing the text as specified in Figure: 28 TAC §3.3874(b)(6)(B), to certify that each individual who sells a long-term care benefit plan for the insurer under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership insurance contracts and how they relate to other public and private coverage of long-term care policies.

(1) The initial certification Form Number LHL571(LTC) must be submitted to the department between June 1, 2009 and June 30, 2009, and the subsequent annual certification Form Number LHL572(LTC) must be submitted annually between January 1 and January 31 of each year for the preceding calendar year beginning in 2010.

(2) Form Number LHL571(LTC) and Form Number LHL572(LTC) are informational filings pursuant to §3.5(b)(1) of this chapter (relating to Filing Authorities and Categories) and are subject to the requirements and procedures set forth in Subchapter A of this chapter.

(3) Any certification form submitted pursuant to this subsection should be filed with the Filings Intake Division, Mail Code 106-1E, Texas Department of Insurance, P.O. Box 149104, Austin, Texas, 78714-9104 or 333 Guadalupe, Austin, Texas, 78701.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
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For further information, please call: (512) 463-6327

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SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES

28 TAC §§3.3848 - 3.3850

The Commissioner of Insurance adopts the repeal of §§3.3848 - 3.3850, concerning long-term care insurance. The repeal is adopted without changes to the proposal as published in the July 18, 2008, issue of the *Texas Register* (33 TexReg 5690).

REASONED JUSTIFICATION. The repeal of §§3.3848 - 3.3850 is necessary because the need for these rules no longer exists and because of the need to promulgate new long-term care partnership rules and amend current long-term care nonpartnership rules. Simultaneously with this adopted repeal and also published in this issue of the *Texas Register,* the Department is adopting amendments to §§3.3801 - 3.3804, 3.3821, 3.3826, 3.3829, 3.3830, 3.3833, 3.3834, 3.3837 - 3.3839, 3.3842, 3.3844, and 3.3846, and new §§3.3848, 3.3849, 3.3860, and 3.3870 - 3.3874. These amendments and new sections are necessary to implement Senate Bill 22, 80th Legislature, Regular Session, relating to a Partnership for Long-Term Care Program.

The repeal of §3.3848, which relates to the form to be used to report rescissions of long-term care insurance policies, is necessary in order to incorporate all of the Subchapter Y reporting requirements for long-term care insurance into §3.3837. The Department is adopting a new §3.3848 to address requirements for limited premium payment options in long-term care policies and certificates. The repeal of §3.3849, pertaining to 1997 effective dates and grace period, is necessary because it is obsolete. The Department is adopting a new §3.3849 to address certain filing and certification requirements for insurers that issue long-term care policies to associations and marketing standards for associations that market the policies. As previously indicated, the adoption of new §3.3848 and §3.3849 is also published in this issue of the *Texas Register.* The repeal of §3.3850, pertaining to Severability, is necessary because these severability provisions are adopted in §3.3803 as part of the promulgation of new long-term care partnership rules in Subchapter Y. The Department is not adopting a new section to replace the repealed §3.3850.

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will result in the removal of obsolete and potentially confusing provisions from the Texas Administrative Code.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department did not receive any comments on the proposed repeal.

STATUTORY AUTHORITY. The repeal of §§3.3848 - 3.3850 is adopted pursuant to the Insurance Code §36.001, which provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Department of Insurance
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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 51. EXECUTIVE

SUBCHAPTER A. PROCEDURES FOR THE ADOPTION OF RULES

31 TAC §51.3

The Texas Parks and Wildlife Commission adopts an amendment to §51.3, concerning Consideration and Disposition of petitions for rulemaking, without changes to the proposed text as published in the October 3, 2008, issue of the *Texas Register* (33 TexReg 8298).

The amendment is necessary as a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires a state agency to review each of its regulations no less frequently than every four years and to readopt, adopt with changes, or repeal each rule as a result of the review.

Under the provisions of Government Code, §2001.021, an interested person by petition may request that a state agency adopt a rule; and each state agency is required to prescribe by rule the form for such petitions and the procedure for the submission, consideration, and disposition of petitions.

Under current rule, all petitions received by the department are forwarded to each member of the commission, accompanied by the staff recommendation to either initiate rulemaking or deny the petition. If within 50 days after the date the department received the petition no commissioner requests that the department initiate rulemaking, the petition is considered denied.

The amendment to subsection (d) alters the current procedure by requiring the executive director, in instances when the staff recommendation is to initiate rulemaking, to place the item on the agenda of a commission meeting. The amendment is intended to streamline the petition process by allowing staff to place items on the agenda instead of having to potentially wait up to 50 days for a response from the commission. The amendment also removes the requirement that the department verify that each commissioner has received petition materials sent to them. The amendment is necessary because the department has determined that it is unnecessary and duplicative. The department mails petition packages to the address on file with the department for each commissioner. If the mail is not deliverable, it will be returned to the department and the department will investigate the problem. Also, many commissioners choose to receive department communications via fax or e-mail rather than by overland mail. Again, if a fax number or e-mail address is inoperable, the department will contact the involved commissioner to rectify the problem.

The amendment to subsection (e) is nonsubstantive, adding language to make the subsection grammatically parallel to the changes made to subsection (d). The amendment also creates new subsection (g), which allows the executive director to deny a petition if the petition seeks essentially the same action as a petition that has been denied within the preceding six months. The amendment is necessary to avoid burdening staff and commissioners with repetitious and unnecessary administrative activities.

The rule as adopted will function by streamlining the department's process for addressing petitions for rulemaking and by making the process more efficient.

The department received no comments opposing adoption of the proposed amendment.

The department received six comments supporting adoption of the proposed amendment.

No groups or associations commented on the adoption of the proposed amendment.

The amendment is adopted under the authority of Government Code, §2001.021, which requires each state agency to prescribe by rule the form for petitions for adoption of rules and the procedure for submission, consideration, and disposition of such petitions.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Ann Bright
General Counsel
Texas Parks and Wildlife Department
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SUBCHAPTER C. EMPLOYEE FUNDRAISING AND SPONSORSHIPS

31 TAC §51.70

The Texas Parks and Wildlife Commission adopts an amendment to §51.70, concerning Gifts to the Department, without changes to the proposed text as published in the October 3, 2008, issue of the *Texas Register* (33 TexReg 8299).

The amendment is necessary as a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires a state agency to review each of its regulations no less frequently than every four years and to readopt, adopt with changes, or repeal each rule as a result of the review.

Under Government Code, §575.003, a state agency that has a governing board may accept a gift of cash or property valued at greater than $500 only if the agency has the authority to accept the gift and a majority of the board, in an open meeting, acknowledges the acceptance of the gift not later than the 90th day after the date the gift is accepted. Under Parks and Wildlife Code, §11.026, the department may accept gifts of property or money in support of any department purpose authorized by the Parks and Wildlife Code. Under Parks and Wildlife Code, §11.0182, the commission is required to adopt policies by rule to govern fund-raising activities by department employees on behalf of the department with respect to gifts of greater than $500.

The amendment alters the current rule to allow the executive director of the department or his or her designee to contingently accept gifts of money or property of more than $500, in accordance with the commission's budget policy, prior to the formal acknowledgment of such gifts by the commission. The commission meets five times per year. The amendment allows the department to more efficiently and immediately utilize gifts in support of agency functions between commission meetings.

The amendment also replaces the word "delegate" with the word "designee" to correct an inaccurate term.

The amendment will function by allowing department to more efficiently and immediately utilize gifts in support of agency functions between commission meetings.

The department received one comment opposing adoption of the proposed rule. The commenter stated that organizations make gifts to the department in order to receive preferential regulatory treatment. The department disagrees with the comment and responds that a gift to the department does not result in special treatment or advantage for the organization or person making the gift. No changes were made as a result of the comment.

The department received five comments supporting adoption of the proposed amendment.

No groups or associations commented for or against adoption of the rule.

The amendment is adopted under the authority of Parks and Wildlife Code, §11.0182, which requires the commission to adopt policies by rule to govern fund-raising activities by department employees on behalf of the department with respect to gifts of greater than $500.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Ann Bright
General Counsel
Texas Parks and Wildlife Department
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SUBCHAPTER D. EDUCATION

31 TAC §51.80

The Texas Parks and Wildlife Commission adopts an amendment to §51.80, concerning Hunter Education Course and Instructors, without changes to the proposed text as published in the October 3, 2008, issue of the *Texas Register* (33 TexReg 8300).

The amendment is necessary as a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires a state agency to review each of its regulations no less frequently than every four years and to readopt, adopt with changes, or repeal each rule as a result of the review.

The amendment establishes a minimum test score of 80 for persons who take the hunter education course online or by home study. The current rule requires a minimum score of 70 on the examination, which is based on the traditional, classroom-style of study personally supervised by a certified hunter education instructor. The intent of the amendment is to create a slightly higher standard for persons who take the course on-line or by correspondence, options that do not include the supervision of a hunter education instructor.

The amendment will function by establishing a minimum score for hunter education certification by persons who take the hunter education course on-line or by correspondence.

The department received three comments opposing adoption of the proposed amendment. Each commenter expressed a rationale or explanation for opposing adoption. The comments, accompanied by the agency's response to each, are as follows.

One commenter stated that people should not be penalized for taking the hunter education course online and that the amendment hinders rather than furthers the goals of hunter education. The department disagrees with the comment and responds that the rule as adopted is not a penalty and is intended to recognize that on-line and correspondence delivery modes that are not supervised by department-certified instructors should have a slightly higher standard in order to ensure that the course materials have been absorbed by the student. The department also responds that there are no data to suggest that on-line or correspondence courses result in less effective hunter education. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department should also require persons who take the hunter educa-

tion course by classroom instruction to score at least 80% on the examination to be certified. The department disagrees with the comment and responds that a passing score of 70% is believed to be sufficient for persons who have taken the classroom version of the hunter education course because the course is conducted by a certified instructor. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the standard should be the same for all methods of course delivery. The department disagrees with the comment and responds that online and correspondence delivery modes that are not supervised by department-certified instructors should have a slightly higher standard in order to ensure that the course materials have been absorbed by the student. The same commenter also stated that "as the years pass, the minimum age for the required certification should as well. i.e. Sept. 1, 1971 would change each consecutive year with a minimum age being constant rather than staying the same and possibly deterring sportsmen from enjoying the sport." The department is unable to determine exactly what the commenter is suggesting, but responds that persons who were 17 years of age or older as of September 1, 1988 are exempt from hunter education requirements by statute (Parks and Wildlife Code, §62.014(d) and the commission cannot modify or eliminate that requirement. No changes were made as a result of the comment.

The department received 20 comments supporting adoption of the proposed amendment.

No groups or associations commented on the adoption of the proposed amendment.

The rule is adopted under the authority of Parks and Wildlife Code, §62.014, which authorizes the department to adopt rules necessary to implement the hunter education program.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Ann Bright
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Texas Parks and Wildlife Department
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CHAPTER 52. STOCKING POLICY

31 TAC §52.101

The Texas Parks and Wildlife Commission adopts an amendment to §52.101, concerning Purpose and Scope, without changes to the proposed text as published in the October 3, 2008, issue of the *Texas Register* (33 TexReg 8301).

The amendment is necessary as a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires a state agency to review each of its regulations no less frequently than every four years and to readopt, adopt with changes, or repeal each rule as a result of the review. The amendment removes the term "undesignated head" and replaces it with the word "chapter." The former is an artifact of a naming convention that is no longer used in the Texas Administrative Code. The amendment also retitles the chapter. The new chapter title is "Stocking Policy," to more accurately reflect the contents of the chapter.

The amendment will function by ensuring that the department's rules employ accurate terminology and title language.

The department received no comments concerning adoption of the proposed amendment.

The amendment is adopted under Parks and Wildlife Code, §§1.012, 12.001, 12.013 - 12.015, and 66.015, which provide the Parks and Wildlife Commission with the authority to promulgate regulations governing the stocking of wildlife in the state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Ann Bright
General Counsel
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CHAPTER 61. DESIGN AND CONSTRUCTION SUBCHAPTER E. GUIDELINES FOR ADMINISTRATION OF TEXAS LOCAL PARKS, RECREATION, AND OPEN SPACE FUND PROGRAM

31 TAC §§61.133 - 61.139

The Texas Parks and Wildlife Commission adopts amendments to §§61.133 - 61.139, concerning Guidelines for Administration of Texas Local Parks, Recreation, and Open Space Fund Program, without changes to the proposed text as published in the October 3, 2008, issue of the *Texas Register* (33 TexReg 8301).

The amendments are necessary as a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires a state agency to review each of its regulations no less frequently than every four years and to readopt, adopt with changes, or repeal each rule as a result of the review.

The amendments to §§61.133 - 61.136, 61.138, and 61.139 implement a new definition of "low-income status." Prior to this year, the rules defined "low-income status" as the "USDA National School Lunch Program Income Eligibility Guidelines federal poverty definition midpoint." The department in a rulemaking earlier this year replaced that definition with a generic definition that recognized low-income status as "any federal determination of low-income status." The department has since learned that the generic definition is too broad. The amendment defines "low-income" as "median income or lower according to the most

recent U.S. census (Median Household Income by State)," which the department has determined is an appropriate standard that can be easily determined by grant applicants seeking to provide recreation and parks services to low-income populations.

The amendment to §61.137, concerning Grants for Regional Parks Grant Programs, consists of several changes.

The amendment to §61.137(a)(2) clarifies that the acquisition priority category includes the development of natural resource areas in addition to their acquisition.

The amendment to §61.137(a)(2) and (3) adds qualifying language to clarify that the term "appropriate development," as used in the section, means development that is consistent with sound ecological management and stewardship of natural resources. The department's primary mission includes the conservation, management, and protection of natural resources. The department believes it is necessary to assist other entities in furthering that mission.

The amendment to §61.137(b)(3) alters a reference to the funding source used by the department to award grants for regional parks. The current rule refers to the "availability of TRPA funds," (Texas Recreation and Parks Account) which, though technically correct, is too broad. The amendment instead references "federal Land and Water Conservation Fund" funds, since the regional parks grants program is entirely funded by the federal Land and Water Conservation Fund.

The amendment to §61.137(b)(6)(A)(iii) provides a more detailed description of what the department evaluates when it considers project proposals that contemplate the acquisition of land for conservation areas and provides that points will not be awarded for proposed acquisitions that are intended to satisfy mitigation requirements. The current rule simply allows for the award of points for prospective acquisitions that would be used as "conservation areas." The department is interested in providing guidance to applicants as to what constitutes "conservation" for the purpose of award. Therefore, the amendment implements qualifying language to clarify that project proposals contemplating the acquisition of land as conservation areas will be evaluated on the extent to which the acquisition would preserve or conserve vulnerable natural resources, ecological processes, or rare, threatened, or endangered species of vegetation or wildlife. The intent of the amendment is to provide guidance as to what can be reasonably considered "conservation." The amendment also provides that points will not be awarded for proposed acquisitions that are intended to satisfy mitigation requirements. The department reasons that if some other, unrelated action by an entity has resulted in the entity's legal obligation to obtain mitigation property, the regional park grants program is not a suitable vehicle for that purpose. The regional park grants program is intended to recognize and assist with free-will conservation efforts and is not intended to function as a funding source for entities that are required to obtain property as a consequence of some other action. The amendment also increases the point award potential from five points to 15 points. The department believes that it is necessary to increase the point potential to emphasize the importance of conservation areas within the context of land acquisition.

The amendment to §61.137(b)(6)(A)(v) provides that projects proposing to offer managed natural resource access must do so in a responsible manner. The amendment is necessary to ensure that an applicant does not offer more or inappropriate access to a natural resource than what is biologically or ecologically acceptable.

Similarly, the amendment to §61.137(b)(6)(B)(i) clarifies that the development of water-based resources is understood by the department to mean development that is consistent with sound ecological management and stewardship. The department does not intend to award points to projects that are antithetical to the department's mission.

The amendment to §61.137(b)(6)(B)(iii) clarifies that conservation of aquatic habitat includes the proposed acquisition of habitat.

The amendment to §61.137(b)(6)(C) eliminates the dedication of publicly owned non-parkland as match contribution and removes irrelevant language. The regional parks grants program is completely funded by the federal Land and Water Conservation Fund. Federal Land and Water Conservation Fund money cannot be matched with public lands. The amendment also clarifies that match must be provided by local units of government to qualify for the award of points. The intent of the section is to encourage the planning and provision of recreational opportunity on a regional scale, which by definition makes coordination and participation among various local units of government desirable. Additionally, the current rule language refers to "sources other than sponsor." The source of match is irrelevant, so long as it is not public land. The amendment to subparagraph (C) also reduces the potential points award from 15 to 5 for the category, because the proposed amendment adds a new §61.137(b)(6)(G) to award points for projects that encourage and reward public/private partnerships. Thus, the scoring coefficient in subparagraph (C) is lowered to compensate for the new category of award.

The amendment to §61.137(b)(6)(F) conditions the award of points under the category of sustainable conservation, allowing for award based in significance of conservation activities, diversity, and/or cost. "Green" technologies or processes are an effective way to restore or maintain ecological integrity of natural systems and reduce operational costs of recreational sites, but are expensive to implement. The department wishes to give additional weight to proposals that would embrace these more efficient and beneficial approaches.

The amendment to §61.137(b)(6) adds a new subparagraph (G) to create a separate priority category for proposal elements that involve commitments of funds or resources from private or nonprofit sources. Under current rule, commitments of funds or resources from any source were evaluated as a single criterion under §61.137(b)(6)(C). The department has determined that segregating the commitment of public resources from private resources is necessary because the department cannot accept publicly-owned land as program match under federal Land and Water Conservation Fund funding rules.

The amendment to §61.137(b)(6) adds a new subparagraph (H) to allow for the award of points based on the degree to which a proposed project would support the department's Land and Water Resources Conservation and Recreation Plan (Plan). The Plan is the core guidance document that drives all of the department's efforts in conservation, management, and recreation.

The rules as adopted will function by providing a uniform method for the submission, analysis, comparison, and ranking of competitive grant applications submitted by local communities seeking parks and recreation funding assistance from the department, and by providing clear and concise definitions that will aid in the administration of the programs governed by the rules.

The department received one comment opposing adoption of the proposed rules. The commenter stated that the funding of "earmarked" projects by the Legislature should be eliminated in order to maintain the integrity of the competitive scoring system identified. The department disagrees with the comment and responds that no specific projects are "earmarked" for funding by the legislature. The legislature created and provides the funding for the Texas Recreation and Parks Account for the specific purpose of funding local parks grants assistance under rules promulgated by the Texas Parks and Wildlife Commission. Those rules are the only basis for project award. No changes were made as a result of the comment.

The department received three comments supporting adoption of the proposed amendments.

No groups or associations commented concerning adoption of the proposed amendments.

The amendments are adopted under Parks and Wildlife Code, Chapter 24, which requires the department to adopt regulations for grant assistance.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Ann Bright
General Counsel
Texas Parks and Wildlife Department
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PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 363. FINANCIAL ASSISTANCE PROGRAMS

The Texas Water Development Board (Board) adopts amendments to §363.16, regarding Pre-design Funding Option, and §363.1005, regarding Approval of Engineering Feasibility Report, without changes to the proposed text as published in the December 12, 2008, issue of the *Texas Register* (33 TexReg 10133).

The adopted amendments to §363.16 and §363.1005 allow the Board to provide funds under the pre-design funding option to applicants from the Board's storage acquisition program and state participation program, including reservoir projects. The pre-design funding option allows the Board to make a commitment for all phases of a project, and to release funds for planning, design, and construction after the prerequisites have been met for each phase, as specified in the terms of the Board's commitment. Previously, §363.16 and §363.1005 did not provide for a Board commitment under the pre-design funding option to fund the planning, design, and construction of storage acquisition and state participation projects, including reservoirs. The original purpose of the limitation was an effort to cull out projects due to very limited funds. It resulted in only projects with completed environmental assessments and preliminary engineering reports being eligible to receive a commitment for construction funds. With expanded funding for State Water Plan projects, these amendments remove this restriction, which is accounting for reduced demand for these funds. The Water Infrastructure Fund, which does not have the same restriction, currently is over-subscribed for the same period of time. Thus, these amendments provide more flexibility for the Board to commit to storage acquisition and state participation projects, including reservoirs.

The adopted amendment to §363.16(b) deletes storage acquisition, state participation, and reservoir projects from the list of financial assistance programs that are currently not eligible for the pre-design funding option. The purpose of allowing for pre-design funding of storage acquisition and state participation projects is to make funding more accessible and thus encourage the use of these funding programs. Under the rule as previously written, applicants for storage acquisition and state participation funding could not obtain a Board commitment until a certain amount of planning has been completed because these types of projects were not eligible for the pre-design funding option under §363.16.

The adopted amendment to §363.1005(a) clarifies that the Executive Administrator must approve the engineering feasibility report before presenting a State Participation application to the Board for commitment, except for pre-design funding. The Board does not make a commitment to fund State Participation projects until the engineering feasibility report is approved in accordance with §363.1005, which means that the appropriate environmental determinations have been completed, the project has been determined to be cost effective, and the applicant has agreed to incorporate all mitigating measures directed by the Executive Administrator. The adopted amendment to §363.1005 allows for a Board commitment to fund a State Participation project under the pre-design option without the Executive Administrator first approving the engineering feasibility report.

No comments were received regarding the proposed amendments.

SUBCHAPTER A. GENERAL PROVISIONS
DIVISION 2. GENERAL APPLICATION PROCEDURES

31 TAC §363.16

The adopted amendment is authorized pursuant to Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900196

Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: February 4, 2009
Proposal publication date: December 12, 2008
For further information, please call: (512) 463-8061

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SUBCHAPTER J. STATE PARTICIPATION PROGRAM

31 TAC §363.1005

The adopted amendment is authorized pursuant to Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900197
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: February 4, 2009
Proposal publication date: December 12, 2008
For further information, please call: (512) 463-8061

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SUBCHAPTER E. ECONOMICALLY DISTRESSED AREAS
DIVISION 1. ECONOMICALLY DISTRESSED AREAS PROGRAM

31 TAC §§363.503 - 363.506, 363.510

The Texas Water Development Board (Board) adopts amendments to §§363.503 - 363.506 and 363.510, relating to the Economically Distressed Areas Program, without changes to the proposed text published in the December 12, 2008, issue of the *Texas Register* (33 TexReg 10134). The text of the rules will not be republished.

The adoption of the amendments to §§363.503 - 363.506 and 363.510 clarify eligibility criteria, repeal unnecessary provisions, and make other non-substantive revisions.

Section 363.503. The adopted amendment of §363.503(1)(B) - (E), and §363.503(2)(B) and (C), clarifies the definitions of inadequate water service and inadequate sewer service. The adopted clarification to §363.503(1)(B) and (C) permits the Board to fund a range of public works system improvements that are consistent with the intent of the statute. In addition, the adopted amendment allows for changes by TCEQ to its rules without requiring a correlative rule amendment by the Board. The adopted amendment to §363.503(1)(D) permits the Board to consider funding water system issues under the concept of inadequate water service that it currently cannot consider.

The adopted amendment to §363.503(1)(E) clarifies the application criteria and procedures under which a project identified in the state water plan and appropriate regional water plan in an economically distressed area may qualify for financing. The adopted language also makes such applications consistent with statutory requirements for economically distressed area financing and with the legislative directives from the 80th Legislature, Regular Session.

The adoption of changes to the definition of §363.503(2)(B) and (C) deletes the reference to specific sections of the TCEQ rules. Should the TCEQ change, repeal, consolidate or move its rules related to minimum standards for public sewer service and on-site sewage facilities, the Board would likewise have to amend its rules. The adopted amendment eliminates that unnecessary administrative burden.

The adoption of the amendment to §363.503(4)(A) removes language that was not helpful in determining the existence of an established subdivision.

Section 363.504. The Board adopts the deletion of subsection (b) from §363.504.

Section 363.505. The Board adopts the amendments to §363.505(a) clarifying that the board may provide funds from the EDAP Account when a sufficient showing is made that one of the three enumerated circumstances is present. The adopted amendment further clarifies that the area to be served must meet the criteria and not the political subdivision that requests assistance.

Non-substantive, editorial changes to §363.506 and §363.510 are adopted without changes.

No public comments were received regarding the proposed amendments.

This rule adoption is authorized pursuant to Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900200
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Effective date: February 4, 2009
Proposal publication date: December 12, 2008
For further information, please call: (512) 463-8061

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31 TAC §363.509

The Texas Water Development Board (Board) adopts the repeal of §363.509 (relating to Minimum Total Loans) without changes to the proposal as published in the December 12, 2008, issue of the *Texas Register* (33 TexReg 10141).

Amendments to §§363.503 - 363.506 and 363.510 describe requirements related to applications for funding from the Economically Distressed Areas Program (EDAP). Amendments to these

provisions are adopted elsewhere in this issue of the *Texas Register* clarifying eligibility criteria and making non-substantive revisions. The repeal of §363.509 is adopted as a part of these revisions to 31 TAC Chapter 363.

No comments were received regarding the proposed repeal.

The adoption of this repeal is authorized pursuant to Texas Water Code §6.101, which authorizes the board to adopt rules necessary to carry out the powers and duties of the board.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 15, 2009.

TRD-200900201
Kenneth L. Petersen
General Counsel
Texas Water Development Board
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For further information, please call: (512) 463-8061

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Reviews

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Texas Alcoholic Beverage Commission

Title 16, Part 3

The Texas Alcoholic Beverage Commission's (TABC) notice of intent to review its Chapter 47 rules, relating to Blanket Rules, was published in the September 26, 2008, issue of the *Texas Register* (33 TexReg 8205).

Based on its statutory review under Government Code §2001.039, TABC has determined that the reasons for adopting the sections in this chapter no longer exist, or have been superseded by other rules. TABC, therefore, repeals Chapter 47.

This concludes TABC's review of its Chapter 47.

TRD-200900193
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Filed: January 14, 2009

The Texas Alcoholic Beverage Commission's (TABC) notice of intent to review its Chapter 49 rules, relating to Production of Alcoholic Beverages, was published in the September 26, 2008, issue of the *Texas Register* (33 TexReg 8205).

Based on its statutory review under Government Code §2001.039, TABC has determined that the reasons for adopting the section in this chapter no longer exist, or have been superseded by other rules. TABC, therefore, repeals Chapter 49.

This concludes TABC's review of its Chapter 49.

TRD-200900194
Alan Steen
Administrator
Texas Alcoholic Beverage Commission
Filed: January 14, 2009

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TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 16 TAC §8.135(d)

Table 1. Typical Penalties.

Rule	Guideline Penalty Amount
16 TAC §3.70-Pipeline Permits Required	$1,000
16 TAC §8.1-General Applicability and Standards	$5,000
16 TAC §8.51-Organization Report	$1,000
16 TAC §8.101-Pipeline Integrity Assessment and Management Plans	$5,000
16 TAC §8.105-Records	$5,000
16 TAC §8.110-Operations and Maintenance Procedures	$5,000
16 TAC §8.115-Construction Commencement Report	$5,000
16 TAC §8.201-Pipeline Safety Program Fees	10% of amt. due
16 TAC §8.203-Supplemental Regulations	$5,000
16 TAC §8.205-Written Procedure for Handling Natural Gas Leak Complaints	$1,000
16 TAC §8.210-Reports	$5,000
16 TAC §8.215-Odorization of Gas	$5,000
16 TAC §8.220-Master Metered Systems	$5,000
16 TAC §8.225-Plastic Pipe Requirements	$5,000
16 TAC §8.230-School Piping Testing	$1,000
16 TAC §8.235-Natural Gas Pipelines Public Education and Liaison	$5,000
16 TAC §8.240-Discontinuance of Service	$10,000
16 TAC §8.301-Records and Reporting	$5,000
16 TAC §8.305-Corrosion Control	$2,500
16 TAC §8.310-Hazardous Liquids and Carbon Dioxide Public Education and Liaison	$5,000
16 TAC §8.315-Hazardous Liquids and Carbon Dioxide Pipeline Located within 1,000 Feet of Public School	$2,500
49 CFR 192.613-Continuing surveillance	$5,000
49 CFR 192.619-Maximum allowable operating pressure	$5,000
49 CFR 192.625-Odorization of gas	$5,000
49 CFR 192 Subpart N-Qualification of Pipeline Personnel	$2,500
49 CFR 192, Subpart O-Pipeline Integrity Management	$5,000
49 CFR Part 192-Transportation of Natural and Other Gas by Pipeline	$1,000
49 CFR Part 193-Liquefied Natural Gas Facilities: Federal Safety Standards	$1,000
49 CFR Part 195-Transportation of Hazardous Liquids by Pipeline	$1,000
49 CFR Part 195.401-General Requirements	$5,000
49 CFR Part 195.406-Maximum Operating Pressure	$5,000
49 CFR Part 195.440-Public Awareness	$2,500
49 CFR Part 195.452-Integrity Management	$5,000
49 CFR Part 195 Subpart G-Qualification of Pipeline Personnel	$2,500
49 CFR Part 199-Drug and Alcohol Testing	$ 500

Figure: 16 TAC §8.135(e)

Table 2. Penalty Enhancements.

For violations that involve	Threatened or actual pollution	Threatened or actual safety hazard	Severity of violation or culpability of person charged
Bay, estuary, or marine habitat	$5,000 to $25,000		
Impact to a residential or public area		$1,000 to $15,000	
Hazardous material release		$2,000 to $25,000	
Reportable incident or accident		$5,000 to $25,000	
Exceeding pressure control limits		$5,000 to $20,000	
Affected area exceeds 100 square feet			$10 per square foot
Time out of compliance			$100 to $2,000 for each month
Reckless conduct of person charged			up to double the total penalty
Intentional conduct of person charged			up to triple the total penalty

Figure 1: 16 TAC §8.135(f)

Table 3. Penalty enhancements based on number of prior violations within seven years.

Number of violations in the seven years prior to action	Enhancement amount
One	$1,000
Two	$2,000
Three	$3,000
Four	$4,000
Five or more	$5,000

Figure 2: 16 TAC §8.135(f)

Table 4. Penalty enhancements based on total amount of prior penalties within seven years.

Total administrative penalties assessed in the seven years prior to action	Enhancement amount
Less than $10,000	$1,000
Between $10,000 and $25,000	$2,500
Between $25,000 and $50,000	$5,000
Between $50,000 and $100,000	$10,000
Over $100,000	10% of total amount

Figure: 16 TAC §8.135(i)

Table 5. Penalty calculation worksheet.

Typical penalties from Table 1		
1. 16 TAC §3.70-Pipeline Permits Required	$1,000	$
2. 16 TAC §8.1-General Applicability and Standards	$5,000	$
3. 16 TAC §8.51-Organization Report	$1,000	$
4. 16 TAC §8.101-Pipeline Integrity Assessment and Management Plans	$5,000	$
5. 16 TAC §8.105-Records	$5,000	$
6. 16 TAC §8.110-Operations and Maintenance Procedures	$5,000	$
7. 16 TAC §8.115-Construction Commencement Report	$5,000	$
8. 16 TAC §8.201-Pipeline Safety Program Fees	10% of amt. due	$
9. 16 TAC §8.203-Supplemental Regulations	$5,000	$
10. 16 TAC §8.205-Written Procedure for Handling Natural Gas Leak Complaints	$1,000	$
11. 16 TAC §8.210-Reports	$5,000	$
12. 16 TAC §8.215-Odorization of Gas	$5,000	$
13. 16 TAC §8.220-Master Metered Systems	$5,000	$
14. 16 TAC §8.225-Plastic Pipe Requirements	$5,000	$
15. 16 TAC §8.230-School Piping Testing	$1,000	$
16. 16 TAC §8.235-Natural Gas Pipelines Public Education and Liaison	$5,000	$
17. 16 TAC §8.240-Discontinuance of Service	$10,000	$
18. 16 TAC §8.301-Records and Reporting	$5,000	$
19. 16 TAC §8.305-Corrosion Control	$2,500	$
20. 16 TAC §8.310-Hazardous Liquids and Carbon Dioxide Public Education and Liaison	$5,000	$
21. 16 TAC §8.315-Hazardous Liquids and Carbon Dioxide Pipelines Located within 1,000 Feet of Public School	$2,500	$
22. 49 CFR 192.613-Continuing surveillance	$5,000	$
23. 49 CFR 192.619-Maximum allowable operating pressure	$5,000	$
24. 49 CFR 192.625-Odorization of gas	$5,000	$
25. 49 CFR 192 Subpart N-Qualification of Pipeline Personnel	$2,500	$
26. 49 CFR Part 192, Subpart O-Pipeline Integrity Management	$5,000	$
27. 49 CFR Part 192-Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards	$1,000	$
28. 49 CFR Part 193-Liquefied Natural Gas Facilities	$1,000	$
29. 49 CFR Part 195-Transportation of Hazardous Liquids by Pipeline	$1,000	$
30. 49 CFR Part 195.401-General Requirements	$5,000	$
31. 49 CFR Part 195.406-Maximum Operating Pressure	$5,000	$
32. 49 CFR Part 195.440-Public Awareness	$2,500	$
33. 49 CFR Part 195.452-Integrity Management	$5,000	$
34. 49 CFR Part 195 Subpart G-Qualification of Pipeline Personnel	$2,500	$
35. 49 CFR Part 199-Drug and Alcohol Testing	$ 500	$
36. Subtotal of typical penalty amounts from Table 1 (lines 1-35, inclusive)		$
37. Reduction for settlement before hearing: up to 50% of line 36 amt.	_____%	$
38. Subtotal: amount shown on line 24 less applicable settlement reduction (line 37)		$
Penalty enhancement amounts for threatened or actual pollution or safety hazard from Table 2		
39. Bay, estuary, or marine habitat	$5,000-$25,000	$
40. Impact to a residential or public area	$1,000-$15,000	$

41. Hazardous material release	$2,000-$25,000	$
42. Reportable incident or accident	$5,000-$25,000	$
43. Exceeding pressure control limits	$5,000-$20,000	$
Penalty enhancements for severity of violation from Table 2		
44. Affected area exceeds 100 square feet	$10 / square foot	$
45. Time out of compliance	$100-$2,000 / mo.	$
46. Subtotal: amount on line 38 plus all amounts on lines 39 through 45, inclusive		$
Penalty enhancements for culpability of person charged from Table 2		
47. Reckless conduct of person charged	double line 46 amt.	$
48. Intentional conduct of person charged	triple line 46 amt.	$
Penalty enhancements for number of prior violations within past seven years from Table 3		
49. One	$1,000	$
50. Two	$2,000	$
51. Three	$3,000	$
52. Four	$4,000	$
53. Five or more	$5,000	$
Penalty enhancements for amount of penalties within past seven years from Table 4		
54. Less than $10,000	$1,000	$
55. Between $10,000 and $25,000	$2,500	$
56. Between $25, 000 and $50,000	$5,000	$
57. Between $50,000 and $100,00	$10,000	$
58. Over $100,000	10% of total amt.	$
59. Subtotal: line 46 plus amounts on lines 47 and/or 48 plus the amount shown on any one line from 49 through 58, inclusive		$
60. Reduction for demonstrated good faith of person charged		$
TOTAL PENALTY AMOUNT: amount on line 59 less any amount shown on line 60		$

Figure: 16 TAC §8.210(e)(7)

PS-95 Semi-Annual Leak Report
Electronic Filing Requirements

The Railroad Commission of Texas (RRC or Commission) has implemented an online system for the filing of Pipeline Integrity reports. The web-based system is a part of the RRC Online system. This document describes Electronic Document Interchange (EDI) filing procedures for the PS-95 Leak Report that is a part of the Pipeline Integrity application.

EDI Filing Option:

a) Capability to file PS-95 Leak Reports via EDI.

b) The new system provides a delimited format allowing filers to easily file via EDI. Anyone using spreadsheet software to compile PS-95 data will be able to export the file to a right curly bracket (}) delimited format for EDI submission.

c) Elimination of the Commission's requirement to submit a test file. The Pipeline Integrity application will validate the format of each file submitted. A file not meeting the formatting requirements will be rejected. The filer will be required to correct the formatting error and resubmit the file. Since this check will be performed each time a file is submitted, the necessity to submit and receive a certification of formatting is redundant and therefore eliminated. However, the Commission will provide EDI filers with the capability to test a file prior to submitting to validate their EDI file format.

d) For specific records not meeting the filing requirements, the filer will receive error/approval feedback on the screen in the form of a message. A file may be resubmitted once all errors are corrected.

Security:

An organization (i.e., a Form P-5 operator) must file a Security Administrator Designation (SAD) Form with the Commission as a requirement for filing online and/or EDI. An account is created for the person designated on the SAD Form as the Security Administrator for the organization. This Security Administrator, in turn, can assign "Filing Rights" to employees of the organization authorizing them to file RRC forms online.

Organizations who have existing SAD forms do not need to re-file. The existing Security Administrators will be able to assign Pipeline Integrity "Filings Rights" to the users within the RRC Online Application.

EDI file and format requirements:

1) Permission to file electronically must be obtained from the Commission via a SAD (Security Administrator Designation) Form. Contact the P-5 department for more information. Information may also be found at http://www.rrc.state.tx.us/formpr/index.html
2) The file will have a delimited format. Only the following delimiter is allowed: a right curly bracket } (rcb)..
3) Numeric columns must not contain any commas—e.g., use 1000000 for one million, not 1,000,000. Nor should columns contain currency formatting like "$" or "USD".
4) Data entry is case sensitive.

Record Layouts:

Identifying Record

Each file submitted to the RRC for EDI processing must have an Identifying Record as the first record in the file. The processing of this record includes the validation that the User ID is authorized to file electronically. An operator may obtain authorization by submitting the Security Administrator Designation form (SAD) to the Commission's P-5 department.

Order	Req-uired	Max Length (in char-acters)	Data Item	Data Type	Description
1	Y	1	Record Type	Integer	Type of record for this identifying record must be 1
2	Y	4	Report Type	Alpha-numeric	Must be PS95.
3	Y	10	User ID	Alpha-numeric	User ID assigned by the RRC to the filer. User ID must match User ID of person logged in
4	Y	32	User Name	Alpha- numeric	Name of the User submitting the file
5	Y	32	User E-mail Address	Character	Email address for the User. Will be used to contact the User and should be valid.
6	Y	6	Operator Number	Integer	Operator Number is the 6 digit number assigned to P-5 Operators by the RRC.
7	Y	4	Report Year	Integer	Reporting year currently being accepted. Format is YYYY.
8	Y	1	Report Period	Integer	1 = 1st half of year, January – June 2 = 2nd half of year, July – December
9	Y	4	Record Count	Integer	Number of records in this filing.

PS-95 Unrepaired Leak Summary Record

Data included in this record type will replace any previously submitted data.

Order	Req.	Max Length	Data Item	Data Type	Description
1	Y	1	Record Type	Integer	Type of Record for Detail Record must be 2.
2	Y	6	Total Grade 1 Unrepaired Leaks for filing period	Integer	Number of unrepaired leaks considered an existing or probable hazard to person or property requiring prompt action. See Leak Classification Lookup Table on page 8 for complete Grade 1 definition.
3	Y	6	Total Grade 2 Unrepaired Leaks for filing period	Integer	Number of unrepaired leaks considered non-hazardous but a probable future hazard. See Leak Classification Lookup Table on page 8 for complete Grade 2 definition.
4	Y	6	Total Grade 3 Unrepaired Leaks for filing period	Integer	Number of unrepaired leaks considered non-hazardous and expected to remain non-hazardous. See Leak Classification Lookup Table on page 8 for complete Grade 3 definition.

PS-95 Leak Report Detail

* Denotes Required in some circumstances. See Description for specifics.

Order	Req.	Max Length	Data Item	Data Type	Description
1	Y	1	Record Type	Integer	Type of Record for Detail Record must be 3
2	Y	6	Pipeline System ID	Integer	System ID is the 6-digit number assigned by the RRC.
3	Y	20	Operator's Leak ID	Alpha- numeric	An Operator-generated number for the leak incident. Must be unique to the incident during that filing period for the Operator. All characters are allowed.
4	Y	8	Date Leak Reported	Integer	Date that the leak was reported, not always the date it occurred including two digit month and day, and 4-digit year. Must be in format (YYYYMMDD). If the specific day is not known, use the first of the month. Date must be prior to or within the current filing period. It may not be a future date.
5	Y	40	Street Address 1	Alpha-numeric	Address where the leak occurred. Address may read "2500 Block of Main Street" if the exact address is not known. **Must be at least 3 characters in length**
6	N	40	Street Address 2	Alpha-numeric	Second Address Line where the leak occurred.
7	Y	40	City	Alpha	City (or nearest city) where the leak occurred. **Must be at least 3 characters in length.**
8	N	5	Zip Code	Integer	5-digit zip code where the leak occurred. If entered, should correspond with the City indicated above.

Order	Req.	Max Length	Data Item	Data Type	Description
9	Y	3	County	Integer	County where the leak occurred. Select an FIPS County Code from County Code Lookup Table beginning on page 13.
10	Y	1	Leak Located	Integer	Valid values are 1 (Above Ground Piping) and 2 (Below Ground Piping). The soil/air interface is considered above ground.
11	Y	2	Leak Located On	Integer	Further pinpoints the location of the leak along the pipeline. Select a value from Located On Lookup Table on page 8.
12	N	7	Material Type	String	Compression Coupling Material Type - Either 'Steel' or 'Plastic'. Required if Leak Located On value equals 12.
13	N	8	Compression Coupling Date	Integer	Date compression coupling installed. Required if Leak Located On value equals 12. Must be in format (YYYYMMDD).
14	Y	1	Facility Type	Integer	Indicates the type of facility affected. Select a code from Facility Type Lookup Table on page 8.
15	Y	4	Pipe Size	Decimal	Decimal representation of IPS pipe size from ½ inch to 12 inches. For example, ½ inch would be .5 or 0.5 or 0.50, 3 ½ inch would be 3.5 or 3.50 and 11 inch would be 11 or 11.0 or 11.00.
16	Y	2	Pipe Type	Integer	Material type where the leak is located. Select a code from Pipe Type Lookup Table on page 9.
17	*	3	Pipe Manufacturer	Alpha- numeric	**If the Pipe Type Code is 8, 9 or 11**, provide a Manufacturer. Select a code from Pipe Manufacturer Lookup Table on page 9.
18	*	3	Pipe ASTM Material Code	Alpha- numeric	**If the Pipe Type is 8, 9 or 11**, provide the ASTM Material Code. See ASTM Code Lookup Table on page 10.
19	Y	1	Leak Classification	Integer	The leak classification is based on the operating and maintenance procedures. Select a code from Leak Classification Lookup Table on page 8.

Order	Req.	Max Length	Data Item	Data Type	Description
20	*	2	Type of Leaking Joint	Integer	The type of joint that leaked. **Required if Located On code is 5 (Joint).** Select a code from Joint Type Lookup Table on page 10.
21	*	2	Type of Leaking Fitting	Integer	The type of fitting that leaked. **Required if Located On code is 4 (Fitting).** Select a code from Fitting Type Lookup Table on page 11.
22	*	20	Coupling Model	Alpha	The model of the coupling that failed. **Required if Located On code is 12.**
23	*	20	Coupling Manufacturer	Alpha	The manufacturer of the coupling that failed. **Required if Located On code is 12.**
24	Y	2	Leak Cause	Integer	The root cause of the failure. Select a code from Leak Cause Lookup Table on page 12.
25	*	250	Other Leak Cause	Alpha- numeric	Further defines an Other Leak Cause. **Required if Other Leak Cause code 81** was entered for Leak Cause. **Must be at least 3 characters in length.**
26	Y	2	Leak Repair Method	Integer	Type of repair that was made. Select a code from Leak Repair Method Lookup Table on page 13.
27	Y	8	Repair Date	Integer	Date the repair was made. The date must be during the reporting period, cannot be a future date, cannot be before the date the leak was reported, and must be formatted YYYYMMDD.

Lookup Tables

Leak Classification Lookup Table

LEAK CLASSIFICATION CODE	DESCRIPTION
1	Grade 1 – A Grade 1 leak is an existing or probable hazard to persons or property and requires the operator to take action immediately to eliminate the hazard and make repairs.
2	Grade 2 – A Grade 2 leak is non-hazardous at the time of detection, but requires the operator to schedule repair based on probable future hazard. It can be scheduled for repair on a normal routine basis with periodic re-inspection as necessary.
3	Grade 3 – A Grade 3 leak is non-hazardous at the time of detection and can be reasonably expected to remain non-hazardous.

Located On Lookup Table

LOCATED ON CODE	DESCRIPTION
1	Valve
2	Body of Pipe
3	Stopcock
4	Fitting
5	Joint
6	Gauge Line
7	Riser
8	Regulator
9	Meter
10	Drip
11	Tap
12	Compression Coupling

Facility Type Lookup

FACILITY TYPE CODE	DESCRIPTION
1	Main
2	Service
3	Transmission

Pipe Type Lookup Table

PIPE TYPE CODE	DESCRIPTION
1	Bare Steel
2	Coated Steel
3	Ductile Iron
4	Cast Iron
5	Galvanized
6	Copper
7	Brass
8	High Density Polyethylene
9	Medium Density Polyethylene
10	Aldyl Polyethylene
11	Poly-Vinyl-Chloride

Pipe Manufacturer Lookup Table (High Density PE, Medium Density PE, or PVC)

CODE	MANUFACTURER
PP1	PolyPipe
PP2	PolyPipe, Inc.
PP3	CSR PolyPipe
RK1	Rinker
PF1	Performance Pipe
PX1	Plexco
DC1	Driscopipe
QU1	Quail
UP1	Uponorr
NP1	Nipak
OTH	Other Manufacturer, not listed, or unknown

ASTM Code Lookup Table (HDPE, MDPE, or PVC) (High Density PE, Medium Density PE, or PVC)

MATERIAL CODE	DESCRIPTION
PA1	Polyamide PA 32312
PB1	Polybutylene PB 2110
PE1	Polyethylene PE 2306
PE2	Polyethylene PE 2406
PE3	Polyethylene PE 3406
PE4	Polyethylene PE 3408
PV1	Polyvinyl Chloride PVC 1120
PV2	Polyvinyl Chloride PVC 1220
PV3	Polyvinyl Chloride PVC 2110
PV4	Polyvinyl Chloride PVC 2116
ABS	Acrylonitrile Butadiene Styrene ABS 1210
CA1	Cellulose Acetate Butyrate CAB MH08
CA2	Cellulose Acetate Butyrate CAB S004
RTR	Reinforced Epoxy Resin RTRP
OTH	Other Material Designation

Joint Type Lookup Table

JOINT TYPE CODE	DESCRIPTION
1	Factory Butt Weld (Steel)
2	Factory Fillet Weld (Steel)
3	Field Butt Weld (Steel)
4	Field Fillet Weld (Steel)
5	Threaded
6	Mechanical Joint
7	Bell & Spigot
8	Flange
9	Butt Fusion (Plastic)
10	Socket Fusion (Plastic)
11	Saddle Fusion (Plastic)
12	Electrofusion (Plastic)
13	Sidewall Fusion (Plastic)
14	Not Applicable
15	Other

Fitting Type Lookup Table

FITTING TYPE CODE	DESCRIPTION
1	Mechanical Service Tee
2	Heat Fusion Service Tee
3	Electrofusion Service Tee
4	Welded Service Tee
5	Saddle Fitting
6	Service Tee Cap
7	Anodeless Meter Riser
8	Threadolets/Weldolets/Sockolets
9	Plugs/Caps
10	Elbow
11	Nipple
12	Tee
13	Diaphragm
14	Other Meter Riser
17	Transition Fitting
18	Split Sleeve
19	Leak Clamp
20	Bell Joint Clamp
21	Meter Swivel
22	Union
23	Insulator
24	Other

Leak Cause Lookup Table

LEAK CAUSE GROUP	LEAK CAUSE CODE	LEAK CAUSE DESCRIPTION
Corrosion Group		
	11	Corrosion
Excavation Group		
	21	Operator Personnel/Contractors Excavating
	22	Other Third Party Excavators
	23	Locator
	24	Vehicle (Auto/Truck/etc.)
Natural Forces Group		
	31	Lightning
	32	Washout
	33	Ground Movement
	34	Ice
	35	Static Electricity
Other Outside Forces Group		
	41	Vandalism
	42	Fire/Explosion First
	43	Excessive Strain
Materials & Welds Group		
	51	Dent
	52	Gouge
	53	Factory Defect
	54	Wrinkle Bend
	55	Weld (Steel)
	56	Fusion Defect (Plastic)
Equipment Group		
	61	Equipment Malfunction
	62	Gasket/O-Ring
	63	Packing
Operations Group		
	71	Inadequate/Failure to Follow Procedures
	72	Stripped Threads
	73	Backfill
Other Group		
	81	Other
	82	Not Excavated

Leak Repair Method Lookup Table

REPAIR METHOD CODE	DESCRIPTION
1	Clamp Installed
2	Split Sleeve
3	Encapsulation
4	Component Replaced
5	Abandoned (Not Replaced)
6	Pipe Replaced
7	Greasing
8	Doped/Caulked
9	Tighten
10	Sealing Bell & Spigot Joint
11	Insertion

County Code Lookup Table

FIPS CODE	COUNTY NAME
001	ANDERSON
003	ANDREWS
005	ANGELINA
007	ARANSAS
009	ARCHER
011	ARMSTRONG
013	ATASCOSA
015	AUSTIN
017	BAILEY
019	BANDERA
021	BASTROP
023	BAYLOR
025	BEE
027	BELL
029	BEXAR

FIPS CODE	COUNTY NAME
031	BLANCO
033	BORDEN
035	BOSQUE
037	BOWIE
039	BRAZORIA
041	BRAZOS
043	BREWSTER
045	BRISCOE
047	BROOKS
049	BROWN
051	BURLESON
053	BURNET
055	CALDWELL
057	CALHOUN
059	CALLAHAN
061	CAMERON
063	CAMP
065	CARSON
067	CASS
069	CASTRO
071	CHAMBERS
073	CHEROKEE
075	CHILDRESS
077	CLAY
079	COCHRAN
081	COKE
083	COLEMAN
085	COLLIN
087	COLLINGSWORTH
089	COLORADO

FIPS CODE	COUNTY NAME
091	COMAL
093	COMANCHE
095	CONCHO
097	COOKE
099	CORYELL
101	COTTLE
103	CRANE
105	CROCKETT
107	CROSBY
109	CULBERSON
111	DALLAM
113	DALLAS
115	DAWSON
117	DEAF SMITH
119	DELTA
121	DENTON
123	DEWITT
125	DICKENS
127	DIMMIT
129	DONLEY
131	DUVAL
133	EASTLAND
135	ECTOR
137	EDWARDS
141	EL PASO
139	ELLIS
143	ERATH
145	FALLS
147	FANNIN
149	FAYETTE

FIPS CODE	COUNTY NAME
151	FISHER
153	FLOYD
155	FOARD
157	FORT BEND
159	FRANKLIN
161	FREESTONE
163	FRIO
165	GAINES
167	GALVESTON
169	GARZA
171	GILLESPIE
173	GLASSCOCK
175	GOLIAD
177	GONZALES
179	GRAY
181	GRAYSON
183	GREGG
185	GRIMES
187	GUADALUPE
189	HALE
191	HALL
193	HAMILTON
195	HANSFORD
197	HARDEMAN
199	HARDIN
201	HARRIS
203	HARRISON
205	HARTLEY
207	HASKELL
209	HAYS

FIPS CODE	COUNTY NAME
211	HEMPHILL
213	HENDERSON
215	HIDALGO
217	HILL
219	HOCKLEY
221	HOOD
223	HOPKINS
225	HOUSTON
227	HOWARD
229	HUDSPETH
231	HUNT
233	HUTCHINSON
235	IRION
237	JACK
239	JACKSON
241	JASPER
243	JEFF DAVIS
245	JEFFERSON
247	JIM HOGG
249	JIM WELLS
251	JOHNSON
253	JONES
255	KARNES
257	KAUFMAN
259	KENDALL
261	KENEDY
263	KENT
265	KERR
267	KIMBLE
269	KING

FIPS CODE	COUNTY NAME
271	KINNEY
273	KLEBERG
275	KNOX
283	LA SALLE
277	LAMAR
279	LAMB
281	LAMPASAS
285	LAVACA
287	LEE
289	LEON
291	LIBERTY
293	LIMESTONE
295	LIPSCOMB
297	LIVE OAK
299	LLANO
301	LOVING
303	LUBBOCK
305	LYNN
313	MADISON
315	MARION
317	MARTIN
319	MASON
321	MATAGORDA
323	MAVERICK
307	MCCULLOCH
309	MCLENNAN
311	MCMULLEN
325	MEDINA
327	MENARD
329	MIDLAND

FIPS CODE	COUNTY NAME
331	MILAM
333	MILLS
335	MITCHELL
337	MONTAGUE
339	MONTGOMERY
341	MOORE
343	MORRIS
345	MOTLEY
347	NACOGDOCHES
349	NAVARRO
351	NEWTON
353	NOLAN
355	NUECES
357	OCHILTREE
359	OLDHAM
361	ORANGE
363	PALO PINTO
365	PANOLA
367	PARKER
369	PARMER
371	PECOS
373	POLK
375	POTTER
377	PRESIDIO
379	RAINS
381	RANDALL
383	REAGAN
385	REAL
387	RED RIVER
389	REEVES

391	REFUGIO
393	ROBERTS
395	ROBERTSON
397	ROCKWALL
399	RUNNELS
401	RUSK
403	SABINE
405	SAN AUGUSTINE
407	SAN JACINTO
409	SAN PATRICIO
411	SAN SABA
413	SCHLEICHER
415	SCURRY
417	SHACKELFORD
419	SHELBY
421	SHERMAN
423	SMITH
425	SOMERVELL
427	STARR
429	STEPHENS
431	STERLING
433	STONEWALL
435	SUTTON
437	SWISHER
439	TARRANT
441	TAYLOR
443	TERRELL
445	TERRY
447	THROCKMORTON
449	TITUS

FIPS CODE	COUNTY NAME
451	TOM GREEN
453	TRAVIS
455	TRINITY
457	TYLER
459	UPSHUR
461	UPTON
463	UVALDE
465	VAL VERDE
467	VAN ZANDT
469	VICTORIA
471	WALKER
473	WALLER
475	WARD
477	WASHINGTON
479	WEBB
481	WHARTON
483	WHEELER
485	WICHITA
487	WILBARGER
489	WILLACY
491	WILLIAMSON
493	WILSON
495	WINKLER
497	WISE
499	WOOD
501	YOAKUM
503	YOUNG
505	ZAPATA
507	ZAVALA

Figure: 28 TAC §3.3829(b)(8)(H)

Long-Term Care Insurance
Personal Worksheet

FOR THE STATE OF TEXAS

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$ _____ per month, or $ _____ per year,] [a one-time single premium of $ _____ .]

Type of Policy (noncancellable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.]

Instructions To Company: Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History

We have sold long-term care insurance since [year] and have sold this [policy/rider], Form No.[____] since (year). [We have never raised rates for any long-term care (policy/rider) sold in this state or any other state.] [We have not raised rates for this (policy/rider) or a similar (policy/rider) in this state or any other state in the last ten years.] [We have raised rates on this (policy/rider) or a similar (policy/rider) in the last ten years. Following is a summary of the rate increases:]

Instructions To Company: A company may use the first bracketed sentence above only if it has never increased rates under any prior individual or group policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar individual or group policy forms in this state or any other state during the last 10 years. The list shall specify the individual or group policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

[☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example by 20%?]

Instructions To Company: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one)

☐ Under $10,000 ☐ $[10-20,000] ☐ $[20-30,000] ☐ $[30-50,000] ☐ Over $50,000

Instructions to Company: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ☐ Yes ☐ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Instructions to Company: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days_____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

☐ Under $20,000 ☐ $20,000-$30,000 ☐ $30,000-$50,000 ☐ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Questions Related to Your Needs

You must be diagnosed with cognitive impairment or be unable to perform two (2) of the following six (6) activities of daily living (ADLs) – bathing, continence, dressing, eating, toileting, and transferring – prior to your long-term care benefits being triggered. Do you understand this policy limitation? ☐ **YES** ☐ **NO**

What type of long-term care service do you anticipate utilizing? (check all that apply)

☐ Nursing home care ☐ Assisted living care ☐ Home health care
☐ Adult day care ☐ Hospice care ☐ Respite care ☐ other services

Disclosure Statement

☐	The answers to the questions above describe my financial situation. OR
☐	I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** ***Instructions to Company:*** This box must be checked.

Signed: _____ _____
(Applicant) (Date)

[☐ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent) (Date)

Agent's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My agent has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____]
(Applicant) (Date)

Instructions to Company: Choose the appropriate sentences depending on whether this is a direct mail or agent sale.

The company may contact you to verify your answers.

Instructions to Company: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

Form Number LHL560(LTC)

Figure: 28 TAC §3.3829(b)(8)(I)

Instructions to Company: This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

FOR THE STATE OF TEXAS

Long-Term Care Insurance Potential Rate Increase Disclosure Form

(Company Name, address & phone number)

1. (Premium rate/Premium rate schedules) that (is/are) applicable to you and that will be in effect until a request is made and filed with the Texas Department of Insurance for an increase (is/are) ($_____) shown on the application. The (premium/premium rate schedule) for this coverage will be (shown on the schedule page of/attached to) your (policy/rider).

2. If your rates are changed, the new rates will become effective on the (next anniversary date/next billing date, etc.). The new rates will remain in effect until another request is made and filed with the Texas Department of Insurance. You have the right to receive a revised (premium rate/premium rate schedule) if the (premium/premium rate schedule) is changed.

3. This long-term care coverage is Guaranteed Renewable. This means that the rates for this coverage may be increased in the future. Your rates CANNOT be increased due to (your increasing age or) declining health, but your rates may go up based on the experience of all insureds with a (policy/rider) similar to yours.

4. If you receive a (premium rate/premium rate schedule) increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

    (a) Pay the increased premium and continue your coverage in force as is.

    (b) Reduce your coverage benefits to a level such that your premiums will not increase.

    (c) Exercise your long-term care nonforfeiture option, if purchased. This option is available for purchase for an additional premium.

    (d) Exercise your contingent nonforfeiture rights - See No. 5. This option is available if you do not purchase a long-term care nonforfeiture option mentioned in (c) above.

5. Contingent Nonforfeiture Rights

If the premium rate for your (policy/rider) goes up in the future and you do not buy a long-term care nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

(a) You will keep some long-term care insurance coverage, if:

(1) Your premium after the increase exceeds your original premium by the percentage shown, or more, in the table (provided on the next page/below); and

(2) You do not pay your premium within 120 days of the increase causing your (policy/rider) to lapse.

(b) The amount of coverage, new lifetime maximum benefit amount, etc., you will keep will equal the total amount of premiums you have paid since your (policy/rider) was first issued. If you have already received benefits under the (policy/rider), so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

(c) Except for this reduced lifetime maximum benefit amount, all other (policy/rider) benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your (policy/rider), with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the (policy/rider) at age 65 and paid the $1,000 annual premium for ten years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to not pay any more premiums causing your (policy/rider) to lapse.
- Your "paid-up" (policy/rider) benefits are $10,000, provided you have at least $10,000 of benefits remaining under your (policy/rider.)

Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That Qualifies for Contingent Nonforfeiture Table

Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

6. Fixed or Limited Premium Payment Period

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies or certificates that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent nonforfeiture benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

(a) The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 - 80	30%
Over 80	10%

(b) You stop paying your premiums within 120 days of when the premium increase took effect; AND

(c) The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

(1) The total lifetime amount of benefits your reduced paid up policy or certificate will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy or certificate becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

(2) The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy or certificate at age 65 with an annual premium payable for 10 years.

- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy or certificate benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy or certificate.

Form Number LHL561(LTC)

Figure: 28 TAC §3.3830(d)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy or certificate to be issued by (Company Name) Insurance Company. Your new policy or certificate (coverage) provides 30 days within which you may decide, without cost, whether you desire to keep the policy or certificate (coverage). For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT (OR OTHER REPRESENTATIVE):

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (pre-existing conditions) may not be covered immediately or fully under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy or certificate (coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also

in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)
(Typed Name and Address of Agent)

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

Figure: 28 TAC §3.3830(e)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE
IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy and certificate (if applicable) delivered herewith issued by (Company Name) Insurance Company. Your new policy or certificate (coverage) provides 30 days within which you may decide, without cost, whether you desire to keep the policy or certificate. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new coverage.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

(1) Health conditions which you may presently have (pre-existing condition) may not be covered immediately or fully under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. Your insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy or certificate (coverage) for similar benefits to the extent such time was satisfied under the original coverage.

(3) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) (To be included only if the application is attached to the policy or other coverage.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new coverage and be sure that all questions are answered fully and correctly. Omissions or material misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 30 days if any formation is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

Figure: 28 TAC §3.3837(a)(2)

Long-Term Care Insurance
Replacement and Lapse Reporting Form

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

For the State of _____ For the Reporting Year of _____

Company Name: _____

Company Address: _____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number: (____)_____

Instructions

The purpose of this form is to specify the information regarding long-term care insurance policy replacements and lapses that insurers are required to report to the Commissioner of Insurance on a statewide basis. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The following two tables indicate the information required in reporting the ten percent (10%) of the insurer's agents with the greatest percentages of replacements and lapses.

Listing of the 10% of Agents with the Greatest Percentage of Replacements

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Replaced by This Agent	Number of Replacements As % of Number Sold By This Agent

Listing of the 10% of Agents with the Greatest Percentage of Lapses

Agent's Name	Number of Policies Sold By This Agent	Number of Policies Lapsed by This Agent	Number of Lapses As % of Number Sold By This Agent

The following table indicates the number of replacement long-term care policies sold as a percentage of the insurer's total annual sales of such policies and the number of lapsed long-term care policies as a percentage of the insurer's total annual sales of such policies.

Company Totals

Company Name: _____

Report Year _____

Replacement Policies Sold	
Annual Policies Sold	
Policies in Force (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Replacement Policies Sold to Policies in Force (as of the end of the preceding calendar year)	
Policies Lapsed	
% of Policies Lapsed to Annual Policies Sold (as of the end of the preceding calendar year)	
% of Policies Lapsed to Policies in Force (as of the end of the preceding calendar year)	

Form Number LHL562(LTC)

Figure: 28 TAC §3.3837(b)

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES

FOR THE STATE OF TEXAS

FOR THE REPORTING YEAR ____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

Address: _____

_____

Phone Number _____

Instructions:

The purpose of this form is to report all rescissions of long-term care insurance policies or certificates for the preceding calendar year. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____

_____

Signature

_____

Name and Title (please print)

_____

Date

Form Number LHL563(LTC)

Figure: 28 TAC §3.3837(c)(2)

Long-Term Care Insurance
Claim Denials Reporting Form

FOR THE STATE OF TEXAS

For the Reporting Year of _____

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

Company Address: _____

_____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in force long-term care insurance policies. "Claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

Indicate the manner of reporting by checking one of the boxes below.

☐ Per Claimant - counts each individual who makes one or a series of claim requests

☐ Per Transaction - counts each claim request

"Denied" means a claim that is not paid for any reason other than for failure to meet the waiting period or because of an applicable preexisting condition. It does not include a request for payment that is in excess of the applicable contractual limits.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 divided by Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit eligibility Criteria Not Met[4]		
11	• Other[5]		

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example: home health care claim filed under a nursing home only policy.
3. Example: a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples: (i) a benefit trigger not met; (ii) certification by a licensed health care practitioner not provided; (iii) no plan of care.
5. Examples: duplicate submission, incomplete claim submission, advance billing.

Form Number LHL564(LTC)

Figure: 28 TAC §3.3837(e)

LONG-TERM CARE POLICIES SOLD REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Instructions: Please include certificates and riders in the information reported below.

Long-Term Care Partnership Policy Type	Number Sold	Average Age
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		

Long-Term Care Non-Partnership Policy Type	Number Sold	Average Age
Comprehensive (institutional and community care)		
Nursing Home (institutional only)		
Home Health Care (community-based services)		
Riders (attached to life policies, annuity contracts)		

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL565(LTC)

Figure: 28 TAC §3.3837(f)(1)

LONG-TERM CARE SUITABILITY REPORTING FORM
FOR THE REPORTING YEAR ____

FOR THE STATE OF TEXAS

Due: No later than June 30 annually for the preceding calendar year

Company Name: _____

NAIC ID Number: _____

TDI ID Number: _____

Suitability Data for Partnership Policies

Long-term Care Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total Number of Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				
Nursing Home (institutional only)				

Suitability Data for Non-Partnership Policies

Long-term Care Non-Partnership Policies	Total Number of Applications Received	Total Number of Applicants Who Declined to Provide Personal Worksheet Information	Total of Applicants Who Did Not Meet Suitability Standards	Total Number of Applicants Who Chose to Confirm After Receiving a Suitability Letter
Comprehensive (institutional and community care)				

Nursing Home (institutional only)				
Home Health Care (community-based services)				
Riders (attached to life policies, annuity contracts)				

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL566(LTC)

Figure: 28 TAC §3.3842(i)(7)

Things You Should Know Before You Buy
Long-Term Care Insurance

Long-Term Care Insurance	• A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Instructions to Company: For single premium policies, delete both of the sentences in the second bullet, and for noncancellable policies, delete the second sentence only in the second bullet.

	• The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does **not** pay for most long-term care.
Medicaid	• Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. • Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency at 1-800-252-8263 or call 211.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a booklet entitled "Long-Term Care Insurance" published by the Texas Department of Insurance. Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling	• The Texas Health Information Counseling and Advocacy Program (HICAP) offers free one-to-one counseling services, concerning whether a long-term care insurance is a suitable option for you, that can be accessed through the toll free number 1-800-252-9250. For insurance agent, insurance company and any other long-term care insurance information, you may call the Consumer Help Line of the Texas Department of Insurance at 1-800-252-3439.
Facilities	• Some long-term care insurance contracts provide for benefit payments in certain facilities only if the facilities are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Form Number LHL567(LTC)

Figure: 28 TAC §3.3842(j)

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Long-Term Care Insurance" published by the Texas Department of Insurance and the disclosure form entitled "Things You Should Know Before Buying Long-Term Care Insurance." The Texas Department of Insurance also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy. You may contact the Department at 1-800-252-3439 or you may go to the Department's web site at www.tdi.state.tx.us.

[You either did not provide any financial information or provided insufficient financial information for us to review.]

Instructions to Company: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application, and issue you a policy.

Please check one box and return in the enclosed envelope.

☐ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Instructions to Company: Delete the phrase in brackets if the applicant did not answer the questions about income.

☐ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE **DATE**

Please return to [issuer] at [address] by [date].

Form Number LHL568(LTC)

Figure: 28 TAC §3.3844(g)(1)

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%

74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Figure: 28 TAC §3.3844(g)(2)

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65 - 80	30%
Over 80	10%

Figure: 28 TAC §3.3848(b)(5)(C)(ii)

Return of Premium Schedule

Long Term Care policy, certificate, or rider with n-premium payment options where n = 5, 6, 7, 8, 9, 10

n = 10		n = 9		n = 8		n = 7		n = 6		n = 5	
Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid	Number of completed policy years	Percentage applied to the excess cumulative premium paid
1	0%	1	0%	1	0%	1	0%	1	0%	1	0%
2	5%	2	6%	2	7%	2	8%	2	9%	2	10%
3	10%	3	12%	3	14%	3	16%	3	18%	3	20%
4	15%	4	18%	4	21%	4	24%	4	27%	4	30%
5	20%	5	24%	5	28%	5	32%	5	36%	5	40%
6	25%	6	30%	6	35%	6	40%	6	45%		
7	30%	7	36%	7	42%	7	48%				
8	35%	8	42%	8	49%						
9	40%	9	48%								
10	45%										

Important Notice: After the end of the [nth] policy year, there will be no return of premium.
Source: Texas Department of Insurance

Form Number LHL574(LTC)

Figure: 28 TAC §3.3849(e)(1)(F)

Insurer Certification of Association Compliance With Marketing Standards for Long-Term Care Partnership and Non-Partnership Policies and Certificates

Due annually between January 1 and January 31 for the preceding calendar year

---

Company Name _____

NAIC ID Number _____

For Calendar Year _____

Date Submitted _____

TDI ID Number _____

I hereby certify that:

Each association as defined in the Insurance Code §1251.052 to whom (company name) has issued a long-term care partnership policy or certificate or non-partnership policy or certificate during (calendar year) has met the requirements of the Texas Administrative Code §3.3849 (relating to Requirements for Insurers that Issue Long-Term Care Policies to Associations and Marketing Standards for Associations that Market the Policies).

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL573(LTC)

Figure: 28 TAC §3.3871(a)(2)(B)(vii)

Partnership Status Disclosure Notice for Long Term Care Partnership Policies/Certificates

Important Information Regarding the Texas Long-Term Care Insurance Partnership Program

Note: It is very important that you keep this Disclosure Notice with your Long-Term Care insurance Policy or Certificate.

Insured Name: _____

Policy Name: _____

Date of Issue: _____

The long-term care insurance policy [certificate] that you have purchased currently qualifies for the Texas Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] may protect your assets through a feature known as an "Asset Disregard," under the Texas Medicaid program. In accordance with the Texas Insurance Code §1651.106, if the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the partnership program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the Texas Medicaid program.

Asset Disregard means that the amount of the policyholder's [certificate holder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply. Asset Disregard is not available under a long-term care insurance policy [certificate] that is not a Partnership Policy [Certificate]. ***The purchase of a Partnership policy, however, does not guarantee you the ability to disregard assets. In addition, the purchase of a Partnership Policy does not automatically qualify you for Medicaid.***

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Texas Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

What Could Disqualify Your Policy [Certificate] Status as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. **Before you make any changes, you should consult with [insert name of insurance company] to determine the effect of a proposed change.** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you may not receive beneficial treatment of your policy [certificate] such as asset disregard under the Medicaid program of that State. The information contained in this Disclosure Notice is based on current Texas and Federal laws. These laws are subject to change.

Additional Information. If you have questions regarding your insurance policy [certificate] please contact [insert the name of insurer]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Texas Health and Human Services Commission by calling 1-800-252-8263 or 211.

Form Number LHL569(LTC)

Figure: 28 TAC §3.3873(a)(2)(F)

Long-Term Care Partnership Program Insurer Certification Form

Section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), authorizes the Texas Commissioner of Insurance upon implementing a qualified State long-term care insurance partnership program ("Qualified Partnership") to certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specific provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act" respectively).

In order to provide the Commissioner of Insurance with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership Program of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

_____
_____
_____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

_____
_____
_____

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

_____
_____
_____

Copies of each of the above referenced policy forms, including any riders and endorsements, shall be provided if required under the provisions of 28 TAC §3.3873 (pertaining to Filing Requirements For Long-Term Care Partnership Policies).

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in Section I.C above?

Yes___ No___ N/A___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the 2000 Model Act relating to such section 6A.

Yes___ No___ N/A___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes___ No___ N/A___ C. Section 6C (relating to extension of benefits).

Yes___ No___ N/A___ D. Section 6D (relating to continuation or conversion of coverage).

Yes___ No___ N/A___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes___ No___ N/A___ F. Section 7 (relating to unintentional lapse).

Yes___ No___ N/A___ G. Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

Yes___ No___ N/A___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes___ No___ N/A___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes___ No___ N/A___ J. Section 12 (relating to minimum standards).

Yes___ No___ N/A___ K. Section 14 (relating to application forms and replacement coverage).

Yes___ No___ N/A___ L. Section 15 (relating to reporting requirements).

Yes___ No___ N/A___ M. Section 22 (relating to filing requirements for marketing).

Yes___ No___ N/A___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

Yes___ No___ N/A___ O. Section 24 (relating to suitability).

Yes___ No___ N/A___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

Yes___ No___ N/A___ Q. Section 26 (the provisions relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702BJ(g)(4)).

Yes___ No___ N/A___ R. Section 29 (relating to standard format outline of coverage).

Yes___ No___ N/A___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership Program that are issued on each of the policy forms identified in section I.C above?

Yes___ No___ N/A___ A. Section 6C (relating to preexisting conditions).

Yes___ No___ N/A___ B. Section 6D (relating to prior hospitalization).

Yes___ No___ N/A___ C. Section 8 (provisions relating to contingent nonforfeiture benefits).

Yes___ No___ N/A___ D. Section 6F (relating to right to return).

Yes___ No___ N/A___ E. Section 6G (relating to outline of coverage).

Yes___ No___ N/A___ F. Section 6H (relating to requirements for certificates under group plans).

Yes___ No___ N/A___ G. Section 6J (relating to policy summary).

Yes___ No___ N/A___ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes___ No___ N/A___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership Program of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the policy forms and endorsements identified in Section C above meet all of the requirements of the 2000 National Association of Insurance Commissioners' Long-Term Care Model Act and Model Regulations that are specified in the Federal Deficit Reduction Act of 2005 (Pub. L. No. 109-171) and further certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

_____
Date

_____
Name and Title of Officer of the Issuer

_____
Signature of Officer of the Issuer

Form Number LHL570(LTC)

Figure: 28 TAC §3.3874(b)(6)(A)

Long-Term Care Partnership Agent Training Certification
Initial Reporting Form
To be submitted to the Department by June 30, 2009

Company Name _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that:

Each individual who currently sells a long-term care benefit plan for (company name) under the Long-Term Care Partnership Program has completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care policies.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL571(LTC)

Figure: 28 TAC §3.3874(b)(6)(B)

Long-Term Care Partnership Agent Training Certification Form
To be submitted to the Department annually between January 1 and January 31 for the preceding year beginning in 2010

Company Name _____

Reporting for Year _____

NAIC ID Number _____

Date Report Submitted _____

TDI ID Number _____

I hereby certify that for the annual period specified above:

Each individual who currently sells or who has sold a long-term care benefit plan for (company name) under the Long-term care Partnership Program completed training and demonstrated evidence of understanding long-term care partnership policies and how they relate to other public and private coverage of long-term care policies.

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip Code: _____

Phone Number: _____ EXT _____

E-mail Address: _____

Form Number LHL572(LTC)

Figure 2: 37 TAC §341.60

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Header	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Header	FILLER		alphanumeric	14		4	17	Blank fill	
Header	Record Type	Record identifier for Header Record.	alphanumeric	2		18	19	Blank fill	
Header	Report Period Begin Date	Should specify the first day of the reporting period.	numeric	8	YYYYMMDD	20	27	Must be a valid date and specify the first day of a month.	
Header	Report Period End Date	Should specify the last day of the reporting period. A multi-month period may be specified.	numeric	8	YYYYMMDD	28	35	Must be a valid date and specify the last day of the reporting period. Must be greater than or equal to the Report Period Begin Date.	
Header	Users Initials	User generating this extraction process.	alphanumeric	3	left-justify, blank fill	36	38	Blank fill	CASEWORKER departments only
Header	CASEWORKER Program Release Number	Used to determine revision of CASEWORKER that created the extracted information.	alphanumeric	8	left-justify, blank fill	39	46	Blank fill	CASEWORKER departments only
Header	Unique Run ID	Date and time of extraction process.	alphanumeric	14	YYYYMMDDHHMMSS	47	60		
Header	Additional Email Address	Specify an additional email address (if any) where the processing log should be sent. The log will automatically be sent to the CJPO's address; this field is to be used only if your department desires a second copy.	alphanumeric	100	left-justify, blank fill	61	160	Blank fill	
Header	Date of Last Comprehensive Folder Edit (CFE)	Information extracted from CASEWORKER systems regarding the status of their last Comprehensive Folder Edit. Used by TJPC to determine future training issues.	numeric	8	YYYYMMDD	161	168	Zero fill	CASEWORKER departments only
Header	Number of Errors on Last CFE		numeric	5	99999	169	173	Zero fill	CASEWORKER departments only
Header	Number of Warnings on Last CFE		numeric	5	99999	174	178	Zero fill	CASEWORKER departments only
Header	Individual error/warning numbers from last CFE.		numeric	205		179	383	Zero fill	CASEWORKER departments only
Header	End of Record Marker		alphanumeric	1		384	384	Must contain '|'	

Decode	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Decode	FILLER		alphanumeric	14		4	17	Blank fill	
Decode	Record Type	Record identifier for Decode Record.	alphanumeric	2		18	19	"00"	
Decode	Decode Type	Specifies the category of the following key (code).	alphanumeric	4	left-justify, blank fill	20	23	DFAC-Detention Facilities DISP-Dispositions PFAC-Placement Facilities PGMT-Programs	
Decode	Decode Key (code)	Key (code) used by department for specified Decode Type (category).	alphanumeric	10	left-justify, blank fill	24	33	Not blank	
Decode	Decode Description	Informative description of the Decode Key (code).	alphanumeric	40	left-justify, blank fill	34	73	Not blank	
Decode	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	74	109	Blank fill	CASEWORKER departments only
Decode	End of Record Marker		alphanumeric	1		110	110	Must contain '|'	

Child	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Child	Personal ID Number	Unique child identifier.	numeric	7	9999999	4	10	0000001..9999999	
Child	FILLER		numeric	7	9999999	11	17	Zero fill	
Child	Record Type	Record identifier for Child Record.	alphanumeric	2		18	19	"01"	
Child	Child's Last Name	The child's last name.	alphanumeric	35	left-justify, blank fill	20	54	Not blank	
Child	Child's First Name	The child's first name.	alphanumeric	35	left-justify, blank fill	55	89	Not blank	
Child	Child's Middle Name	The child's middle name.	alphanumeric	35	left-justify, blank fill	90	124		
Child	Child's Name Suffix	The child's name suffix.	alphanumeric	3	left-justify, blank fill	125	127		
Child	Race	The child's race/ethnicity.	alphanumeric	1		128	128	A-Asian B-African American H-Hispanic I-American Indian O-Other U-Unknown W-White	Cannot be Unknown (U) if the child has one or more formal or paper-formalized referrals.
Child	Sex	The child's gender.	alphanumeric	1		129	129	M-Male F-Female U-Unknown	Cannot be Unknown (U) if the child has one or more formal or paper-formalized referrals.
Child	Date of Birth	The child's date of birth.	numeric	8	YYYYMMDD	130	137	Valid date between 1/1/1900 and 12/31/2099	
Child	Social Security Number	The child's social security number.	numeric	9	999999999	#REF!	#REF!	000000000..999999999	
Child	Zip Code	Zip code of the child's residence.	numeric	9	999999999	#REF!	#REF!	000000000..999999999 5-digit zip code is acceptable with trailing zeros.	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Child	Child Lives With	Specifies the person(s) with whom the child lives. If the makeup of the child's household differs from the options provided, list the principal caretaker.	alphanumeric	4	left-justify, blank fill	#REF!	#REF!	BOTH-Two parents (natural or adoptive) BLEN-combination of two parents (natural and step or adoptive and step) FATH-Father (natural, adoptive or step) MOTH-Mother (natural, adoptive or step) GPAR-Grandparent(s) GARD-Legal guardian (non-family) RELA-Other relative(s) FOST-Foster family GRUP-Group home or institution that provides 24 hour care SELF-Child lives alone SPOU-Spouse (child's legal or common-law) FRND-Friend (peer, adult friend, or boyfriend/girlfriend) OTHR-Other UNKN-Unknown	
Child	Special Education?	Has the child been identified as a special education student?	alphanumeric	1		#REF!	#REF!	Y, N or U	
Child	Special Education Handicapping Condition	If the child has been identified as a special education student, specify the primary handicapping condition.	alphanumeric	2	left-justify, blank fill	#REF!	#REF!	ED-Emotionally Disturbed LD-Learning Disabled MR-Mentally Retarded OT-Other PD-Physical Disability UN-Unknown	Required if the Special Education field is 'Y', otherwise blank fill.
Child	Mental Health Needs	Does the child have mental health needs?	alphanumeric	1	left-justify, blank fill	#REF!	#REF!	Y, N or U	
Child	Date Determined Mentally Ill	Date that the child was first determined to have mental health needs (by the department).	numeric	8	YYYYMMDD	#REF!	#REF!	Valid date between 1/1/1900 and 12/31/2099	Required if the Mental Health Needs field is 'Y'. Otherwise zero fill.
Child	In Treatment?	Is the child currently in mental health treatment?	alphanumeric	1		#REF!	#REF!	Y, N, U or blank fill if not applicable.	Required if the Mental Health Needs field is 'Y'. Otherwise blank fill.
Child	Diagnosis	What is the child's primary diagnosed mental health condition?	alphanumeric	2		#REF!	#REF!	AJ-Adjustment Disorder AD-Attention Deficit Hyperactivity Disorder BP-Bipolar CD-Conduct Disorder CG-Cognitive Disorder DA-Dissociative Disorder DD-Disruptive Disorder DF-Oppositional Defiant Disorder DN-Depression Not Otherwise Specified ED-Eating Disorder GA-Generalized Anxiety IC-Impulse Control Disorder MD-Major Depression MR-Mental Retardation OA-Other Anxiety Disorder OC-Other Childhood Disorder OM-Other Mood Disorder OP-Other Psychotic Disorder OT-Other Disorder PD-Personality Disorder PS-Post Traumatic Stress Disorder PV-Pervasive Developmental Disorder SA-Schizoaffective SZ-Schizophrenia UN-Unknown Blank fill if not applicable.	Required if the Mental Health Needs field is 'Y'. Otherwise blank fill.
Child	Gang Affiliation/Membership	Is the juvenile currently or has the juvenile ever been affiliated with a gang?	alphanumeric	1		#REF!	#REF!	Y, N, S (suspected), or U	
Child	Sexual Abuse?	Has the child ever been a victim of sexual abuse?	alphanumeric	1		#REF!	#REF!	Y, N, S (suspected), or U	
Child	Physical Abuse?	Has the child ever been a victim of physical abuse?	alphanumeric	1		#REF!	#REF!	Y, N, S (suspected), or U	
Child	Emotional Abuse?	Has the child ever been a victim of emotional abuse?	alphanumeric	1		#REF!	#REF!	Y, N, S (suspected), or U	
Child	DPS SID Number	The child's State Identification Number (SID) as issued by the Department of Public Safety	alphanumeric	8	99999999	#REF!	#REF!	00000000..99999999 or blank fill	
Child	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	#REF!	#REF!	Blank fill	CASEWORKER departments only
Child	End of Record Marker		alphanumeric	1		#REF!	#REF!	Must contain '|'	

Referral	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Referral	Personal ID Number	Unique child identifier.	numeric	7	9999999	4	10	0000001..9999999	
Referral	Referral Number	Unique referral identifier.	numeric	7	9999999	11	17	0000000..9999999	
Referral	Record Type	Record identifier for Referral Record.	alphanumeric	2		18	19	"03"	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Referral	Referral Type	Type of referral. Definitions of these categories are available on the TJPC website.	alphanumeric	2		20	21	FM-Formal PF-Paper Formalized PA-Paper Complaint CS-Courtesy Supervision TR-Interim/Permanent Transfer CI-Crisis Intervention CD-Contract Detention CP-Contract Placement NJ-Non-Jurisdiction IC-Interstate Compact	Courtesy Supervision (CS) only valid for offenses that occurred prior to September 1, 2005.
Referral	Referral Date	For formal, paper formalized and crisis intervention referral types, the referral date is when face-to-face contact with the child occurs. For paper complaints, it is the date that the department received the complaint. For non-jurisdictional, contract placements and detentions, and interstate compact, it is the date the child was received. For transfers, it is the official supervision start date.	numeric	8	YYYYMMDD	22	29	Valid date between 1/1/1900 and 12/31/2099.	
Referral	County Number	County referring the child. Same as Headquarter County Number unless referred to a multi-county jurisdiction. If Referral Type is Contract Detention, Contract Placement or Non-Jurisdiction, indicate the referring county or use a special identifier (755-759) if applicable.	numeric	3	999	30	32	001..254 755-Other State 756-TYC 757-INS 758-Other U.S. Government Agency 759-State or Local Government Agency	County specified must be within the department's jurisdiction or special identifier (755-758).
Referral	School Status	School status at time of referral.	alphanumeric	2		33	34	IS-In Regular School DO-Dropped Out SE-Suspended/Expelled GD-GED GR-Graduated HS-Home School AE-Alternative Education JJ-Juvenile Justice Alternative Education Program CS-Charter School PS-Private School UN-Unknown	Required for all Formal and Paper Formalized referrals, otherwise blank fill.
Referral	Last Grade Completed	The last grade completed by the child at time of referral.	numeric	2	99	35	36	00..12	Must be non-zero value if School Status is known.
Referral	Substance Abuse	Is the juvenile in need of substance abuse services?	alphanumeric	1		37	37	Y-Yes, not being treated T-Yes, being treated N-No S-Suspected U-Unknown	Required for all Formal and Paper Formalized referrals, otherwise blank fill.
Referral	Referral Source	The agency referring the child to the probation department.	alphanumeric	1		38	38	P-Law Enforcement Agency S-School D-Probation Department O-Other T-TYC	
Referral	Primary Alleged Offense	At intake, the most serious offense the child is alleged to have committed.	alphanumeric	8	99999999	39	46	A valid TJPC-DPS offense code. A current list of codes may be obtained from TJPC's website or by contacting TJPC directly.	An Offense Record must exist for this referral with the same offense code and the Alleged Offense Indicator field must contain 'P'.
Referral	Primary Alleged Offense Preparatory Code	Designates that the Primary Alleged Offense was a preparatory (attempted, conspired or solicited) offense. Reduces offense by one degree.	alphanumeric	1		47	47	A-Attempted C-Conspired S-Solicited Blank fill if no modification	
Referral	Primary Disposition Offense Code	The most serious offense at disposition of the referral.	alphanumeric	8	99999999	48	55	A valid TJPC-DPS offense code. A current list of codes may be obtained from TJPC's website or by contacting TJPC directly.	An Offense Record must exist for this referral with the same offense code and the Disposition Indicator field must contain 'P'.
Referral	Primary Disposition Offense Preparatory Code	Designates that the Primary Disposition Offense was a preparatory (attempted, conspired or solicited) offense. Reduces offense by one degree.	alphanumeric	1		56	56	A-Attempted C-Conspired S-Solicited Blank fill if no modification	
Referral	Primary Disposition	Department defined code for disposition.	alphanumeric	4	left-justify, blank fill	57	60	Department specified code.	Required if Disposition Date field completed. Must include a Decode Record for each code specified.

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Referral	Primary Disposition (TJPC category)	Summarized category of Primary Disposition field as defined by TJPC. Definitions of these categories are available on the TJPC website.	numeric	3	999	61	63	Department Actions: 010-Dismissed or Withdrawn 020-Supervisory Caution 030-Deferred Prosecution Prosecutor Actions: 040-No Probable Cause/Dismissed 050-Refused 051-Non-Suited 060-Supervisory Caution 070-Deferred Prosecution Court Actions: 080-Dismissed 081-Not Guilty 082-Adjudicated with no Disposition 090-Supervisory Caution 100-Deferred Prosecution 110-Adjudicated to Probation 111-Determinate Sentence Probation 120-Modified/Extended Probation 130-Indeterminate Commitment to TYC 135-Concurrent Sentence to TYC 140-Determinate Commitment to TYC 150-Certified as an Adult 910-Consolidated and Disposed in Another Case 920-Transferred with no Disposition	Required if Disposition Date field completed.
Referral	Disposition Date	Date a disposition was assigned to this referral.	numeric	8	YYYYMMDD	64	71	Valid date between 1/1/1900 and 12/31/2099. Zero fill if not applicable.	
Referral	Determinate Sentence Months	The total number of months ordered if the child is either committed to the Texas Youth Commission or placed on probation for a determinate sentence.	numeric	3	999	72	74	001..999 or zero fill if not applicable.	Required if Primary Disposition(TJPC category) value equals 111 or 140.
Referral	Diverted to Where	Designates the type of agency, organization or program (outside of the juvenile justice system) where the child was diverted. Do not complete this field for children who are under supervision, committed to TYC or certified as an adult. Definitions of these categories are available on the TJPC website.	alphanumeric	4	left-justify, blank fill	75	78	MHTH-Mental Health Services FCPS-Family/Child Protective Services DAC-Drug & Alcohol Counseling FOP-First Offender Program STAR-STAR/Prevention Program SCHL-School Resources TRUP-Truancy Program VICT-Victim Mediation OTHR-Other Blank fill if not applicable.	
The following section provides for two subsequent dispositions. This section is used only for children who violate the terms of their deferred prosecution and are subsequently adjudicated on the same referral, or for dispositions that are appealed and are subsequently assigned a different disposition. It is not used for modifications. See descriptions and edit criteria above.									
Referral	Subsequent Primary Disposition	See descriptions above.	alphanumeric	4	left-justify, blank fill	79	82	See edit criteria above.	See dependencies above.
Referral	Subsequent Primary Disposition (TJPC category)		numeric	3	999	83	85		
Referral	Subsequent Disposition Date		numeric	8	YYYYMMDD	86	93		
Referral	Subsequent Determinate Sentence Months		numeric	3	999	94	96		
Referral	Subsequent Diverted to Where		alphanumeric	4	left-justify, blank fill	97	100		
Referral	Subsequent Primary Disposition	See descriptions above.	alphanumeric	4	left-justify, blank fill	101	104	See edit criteria above.	See dependencies above.
Referral	Subsequent Primary Disposition (TJPC category)		numeric	3	999	105	107		
Referral	Subsequent Disposition Date		numeric	8	YYYYMMDD	108	115		
Referral	Subsequent Determinate Sentence Months		numeric	3	999	116	118		
Referral	Subsequent Diverted to Where		alphanumeric	4	left-justify, blank fill	119	122		
End of subsequent disposition section.									
Referral	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	123	158	Blank fill	CASEWORKER departments only
Referral	End of Record Marker		alphanumeric	1		159	159	Must contain '|'	

Detention	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Detention	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Detention	Referral Number	Specifies the referral for which this secure detention applies.	numeric	7	9999999	11	17	0000001..9999999	
Detention	Record Type	Record identifier for Detention Record.	alphanumeric	2		18	19	"DN"	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Detention	Detention Sequence Number	Uniquely identifies this detention record from all other detention records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique detention event. Once assigned it should not be changed.
Detention	Detention Facility	TJPC registered facility identification number for secure detention facilities in Texas or department defined code for facilities outside of Texas.	alphanumeric	7	left-justify, blank fill	26	32	If facility is within Texas then code must be a TJPC registered facility identification code, otherwise a department specified code.	If facility is not in Texas then include a Decode Record for each code specified.
Detention	Date Detained	The date the child was placed in detention.	numeric	8	YYYYMMDD	33	40	Valid date between 1/1/1900 and 12/31/2099.	
Detention	Time Detained	The time the child was placed in detention.	numeric	4	HHMM	41	44	HH between 00..23 and MM between 00..59. 0000 is considered midnight.	
Detention	Date Released	The date the child was released from detention.	numeric	8	YYYYMMDD	45	52	Valid date between 1/1/1900 and 12/31/2099 and greater than or equal to the Date Detained. Zero fill if not applicable.	
Detention	Time Released	The time the child was released from detention.	numeric	4	HHMM	53	56	HH between 00..23 and MM between 00..59. 0000 is considered midnight.	Required if Date Released field completed.
Detention	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	57	92	Blank fill	CASEWORKER departments only
Detention	End of Record Marker		alphanumeric	1		93	93	Must contain '|'	
MAYSI	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
MAYSI	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
MAYSI	Referral Number	Specifies the referral for which this MAYSI screening applies.	numeric	7	9999999	11	17	0000001..9999999	
MAYSI	Record Type	Record identifier for MAYSI Record.	alphanumeric	2		18	19	"MA"	
MAYSI	MAYSI Sequence Number	Uniquely identifies this MAYSI record from all other MAYSI records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique MAYSI event. Once assigned it should not be changed.
MAYSI	Screening Date	Date the screening instrument was administered to the child for the specified referral. If the MAYSI was not administered, enter the date that the department attempted to administer the instrument or the date an assessment was administered. If the child was already in detention or in treatment, enter the referral date.	numeric	8	YYYYMMDD	26	33	Valid date between 1/1/1900 and 12/31/2099.	
MAYSI	Administered?	Was the MASYI-2 administered to the juvenile?	alphanumeric	1		34	34	Y or N	
MAYSI	Reason Not Administered	Why was the MAYSI-2 not administered?	alphanumeric	1		35	35	A-Assessed by mental health professional D-Child already in detention at time of referral E-Child is non-English speaking R-Child Refused Test T-Child is already in treatment for mental health U-Child is physically or mentally unable O-Other reason	Required if Administered value is "N". Blank fill if not applicable.
MAYSI	Alcohol/Drug Use (AD) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		36	36	0..8 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Angry-Irritable (AI) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		37	37	0..9 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Depressed-Anxious (DA) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		38	38	0..9 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Somatic Complaints (SC) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		39	39	0..6 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Suicide Ideation (SI) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		40	40	0..5 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Thought Disturbance BOYS (TD) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		41	41	0..5 or blank fill if not applicable.	Required if Administered value is "Y" and Sex is "M". If Sex is "F", blank fill.
MAYSI	Traumatic Experiences (TE) Score	Refer to MAYSI-2 Scoring Summary.	alphanumeric	1		42	42	0..5 or blank fill if not applicable.	Required if Administered value is "Y".
MAYSI	Referred for Subsequent Assessment?	Was the child referred to a mental health professional for a subsequent assessment based on the MAYSI results?	alphanumeric	1		43	43	Y or N	Required if Administered value is "Y".
MAYSI	Referred to Where	If the child was referred for a subsequent assessment, to what type of provider was he/she referred?	alphanumeric	1		44	44	C-Contract Provider I-In-house Staff M-Local MHMR P-Private Provider O-Other	Required if Referred for Subsequent Assessment value is "Y".
MAYSI	Subsequent Assessment?	Did the child receive a subsequent assessment by a mental heath professional?	alphanumeric	1		45	45	Y, N, U (unknown) or blank fill if not applicable.	Required if Referred for Subsequent Assessment value is "Y".
MAYSI	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	46	81	Blank fill	CASEWORKER departments only
MAYSI	End of Record Marker		alphanumeric	1		82	82	Must contain '|'	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Behavioral Health	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Behavioral Health	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Behavioral Health	FILLER		numeric	7	9999999	11	17	Zero fill	
Behavioral Health	Record Type	Record identifier for Behaviorial Health Record.	alphanumeric	2		18	19	"BH"	
Behavioral Health	Behaviorial Health Sequence Number	Uniquely identifies this behaviorial health record from all other behaviorial health records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number to determine unique behavioral health event. Once assigned it should not be changed.
Behavioral Health	Referral Date	The date that the child was referred to the mental health or substance abuse provider.	numeric	8	YYYYMMDD	26	33	Valid date between 1/1/1900 and 12/31/2099.	
Behavioral Health	Presenting Problem	The type of behaviorial health service to which the juvenile is being referred.	alphanumeric	1		34	34	M-Mental Health S-Substance Abuse	
Behavioral Health	Referred For	For what was the child referred?	alphanumeric	1		35	35	A-Assessment/Evaluation C-Crisis Intervention E-Screening S-Service O-Other	
Behavioral Health	Referred To	To what type of provider was the child referred?	alphanumeric	1		36	36	C-Contract Provider I-In-house Staff M-Local MH/Substance Abuse Provider P-Private Provider O-Other	
Behavioral Health	Referral Outcome	What was the outcome of this referral?	alphanumeric	1		37	37	C-Completed N-Not Completed P-Pending U-Unknown Outcome	
Behavioral Health	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	38	73	Blank fill	CASEWORKER departments only
Behavioral Health	End of Record Marker		alphanumeric	1		74	74	Must contain "|"	

Offense	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Offense	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Offense	Referral Number	Specifies the referral for which this offense applies.	numeric	7	9999999	11	17	0000001..9999999	
Offense	Record Type	Record identifier for Offense Record.	alphanumeric	2		18	19	"OF"	
Offense	Unique Offense Number	Uniquely identifies this offense record from all other offense records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique offense event. Once assigned it should not be changed.
Offense	Alleged Offense Date	The date the alleged offense occurred.	numeric	8	YYYYMMDD	26	33	Valid date between 1/1/1900 and 12/31/2099.	
Offense	Alleged Offense Counts	Used to specify multiple occurrences (counts) of the same offense and incident.	numeric	2	99	34	35	01..99	
Offense	Alleged Offense Code	Used to designate the DPS offense code for the alleged offense.	alphanumeric	8	99999999	36	43	A valid TJPC-DPS offense code. A current list of codes may be obtained from TJPC's website or by contacting TJPC directly.	
Offense	Alleged Offense Preparatory Code	Used to designate the Alleged Offense was a preparatory offense.	alphanumeric	1		44	44	A-Attempted C-Conspired S-Solicited Blank fill if no modification	
Offense	Alleged Offense Indicator	Designates the status of the offense at time of intake. An offense may be designated as a primary or secondary offense. However, if during disposition the child is being disposed on an offense not originally listed, enter a new offense and designate it as 'added at disposition' or 'revised at disposition'.	alphanumeric	1		45	45	P-Primary alleged offense S-Secondary alleged offense R-Revised offense at time of disposition A-Added offense at time of disposition	Only one offense within a referral may be designated as the primary alleged offense.
Offense	Disposition Indicator	Designates the status of the offense at time of disposition.	alphanumeric	1		46	46	P-Primary disposition offense C-Consolidated with primary offense D-Dismissed (not included in the disposition)	Only one offense within a referral may be designated as the primary disposition offense.

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Offense	Weapon Used	Specifies the type of weapon used during the commission of the offense.	alphanumeric	2		47	48	BK-Brass Knuckles CL-Club or other similar device EX-Explosives/Explosive Weapon HB-Hoax Bomb HG-Handgun KN-Knife MA -Mace or other chemical dispensing device RI-Rifle SG-Shotgun OG-Other Gun OT-Other Blank fill if not applicable.	
Offense	School Related Location	Specifies the offense occurred on a school campus or during a school related activity.	alphanumeric	4	left-justify, blank fill	49	52	OCAM-On Campus OTHR-School Related Activity-On/Off Campus Blank fill if not applicable.	
Offense	School Campus Number	Specifies the Texas Education Agency (TEA) assigned campus number where the offense took place. If the offense occurred 'in transit' then use the home campus number. May be obtained from the local campus, school district or Texas Education Agency (TEA).	numeric	9	999999999	53	61	000000000..999999999 or zero fill if not applicable.	Required if School Related Location field is "OCAM". Zero fill if not applicable.
Offense	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	62	97	Blank fill	CASEWORKER departments only
Offense	End of Record Marker		alphanumeric	1		98	98	Must contain '|'	

Placement	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Placement	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Placement	Referral Number	Specifies the referral for which this placement applies.	numeric	7	9999999	11	17	0000001..9999999	
Placement	Record Type	Record identifier for Placement Record.	alphanumeric	2		18	19	"PL"	
Placement	Placement Sequence Number	Uniquely identifies this placement record from all other placement records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique placement event. Once assigned it should not be changed.
Placement	Placement Facility	TJPC registered facility identification number or department defined code for placement facility.	alphanumeric	7	left-justify, blank fill	26	32	If Placement Type is Secure Correctional (S) then code must be a TJPC registered facility identification code.	If Placement Type is not Secure Correctional (S) then include a Decode Record for each code specified.
Placement	Placement Type	Type of residential placement used.	alphanumeric	1		33	33	E-Emergency F-CPS Placement K-Kinship Placement (by court) L-Foster Care P-Parental Placement S-Secure Correctional R-Residential (non-secure)	
Placement	Service Type	Description of the primary service delivered at the facility.	alphanumeric	1		34	34	B-Bootcamp C-Correctional ~~F-Foster Care~~ G-Female Offender M-Mental Health P-Pregnant Female S-Substance Abuse T-Treatment X-Sex Offender O-Other	Required if Placement Type field is not Emergency Shelter (E).
Placement	Cost Per Day	Specifies per day charge for this placement. Zero specifies a no-cost (free) placement. If the cost per day changes during the placement, create a new record.	numeric	5	999.99 (implied decimal)	35	39	$000.00..$500.00	
Placement	Level of Care	Level of care as defined by the Texas Department of Family Protective Services (FPS). Definitions of these categories are available on the TJPC website.	alphanumeric	1		40	40	E-Emergency B-Basic M-Moderate S-Specialized I-Intensive U-Unknown Blank fill if not applicable.	If the placement ended prior to 9/1/2003, then the old Levels of Care (1..6) should be used.
Placement	Placement Date In	The date the child entered the placement facility.	numeric	8	YYYYMMDD	41	48	Valid date between 1/1/1900 and 12/31/2099.	
Placement	Placement Date Out	The date the child exited the placement facility.	numeric	8	YYYYMMDD	49	56	Valid date between 1/1/1900 and 12/31/2099 and greater than or equal to the Placement Date In. Zero fill if not applicable.	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Placement	Discharge Reason	Specifies the reason the child left the facility. Definitions of these categories are available on the TJPC website.	alphanumeric	1		57	57	S-Completed B-Absent without Permission C-Changed Facilities/Cost Per Day Changed D-Deceased F-Depletion of Funds/Closure J-Transferred out of Jurisdiction U-Unsuitable/Not Eligible X-Failure to Comply	Required if Placement Date Out field completed. If 'C' is used a new Placement Record must exist.
Placement	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	58	93	Blank fill	CASEWORKER departments only
Placement	End of Record Marker		alphanumeric	1		94	94	Must contain '|'	
Program	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Program	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Program	Referral Number	Specifies the referral for which this program applies.	numeric	7	9999999	11	17	0000001..9999999	
Program	Record Type	Record identifier for Program Record.	alphanumeric	2		18	19	"PG"	
Program	Program Sequence Number	Uniquely identifies this program record from all other program records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique program event. Once assigned it should not be changed.
Program	Program Name	Department defined code for the program.	alphanumeric	4	left-justify, blank fill	26	29	Department specified code.	Must include a Decode Record for each code specified.
Program	Program Provider	Type of provider for program.	alphanumeric	1		30	30	C-Contract Provider I-In-House Staff M-Local MH/Gov't Provider P-Private Provider O-Other	
Program	Program Type	Summarizes the program into specific categories based on its primary purpose. Definitions of these categories are available on the TJPC website.	alphanumeric	3		31	33	ANG-Anger Management/Conflict Resolution BJP-Border Justice Project CNS-Counseling Services COG-Cognitive Behavioral CSR-Community Service/Restitution DCT-Drug Court ERL-Early Intervention/First Referral EDU-Educational ELM-Electronic Monitoring ETH-Equine Therapy EXP-Experiential Education DAY-Extended Day Program/Day Boot Camp FAM-Family Preservation FPT-Family Preservation Targeted FEM-Female Offender GNG-Gang Prevention/Intervention ICM-Intensive Case Management ISP-Intensive Supervision IST-Intensive Supervision Targeted LIF-Life Skills MEN-Mentor MTL-Mental Health MHT-Mental Health Targeted MCT-Mental Health Court MRT-Mental Retardation RUN-Runaway/Truancy SOF-Sex Offender SOT-Sex Offender Targeted SAP-Substance Abuse Prevention/Intervention SUT-Substance Abuse Treatment SAT-Substance Abuse Treatment Targeted VMD-Victim Mediation	
Program	Program Referral Date	The date that the child was referred to the program. (This is generally not the same date at the program begin date.)	numeric	8	YYYYMMDD	34	41	Valid date between 1/1/1900 and 12/31/2099.	
Program	Program Begin Date	The date the child physically began the program.	numeric	8	YYYYMMDD	42	49	Valid date between 1/1/1900 and 12/31/2099. Zero fill if not applicable.	Required when the child enters the program.
Program	Program End Date	The date the child exited the program.	numeric	8	YYYYMMDD	50	57	Valid date between 1/1/1900 and 12/31/2099 and greater than or equal to the Program Begin Date. Zero fill if not applicable.	

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Program	Program Outcome	Specifies the program outcome. Definitions of these categories are available on the TJPC website.	alphanumeric	1		58	58	S-Completed B-Absent without Permission D-Deceased F-Depletion of Funds/Closure J-Transferred out of Jurisdiction U-Unsuitable/Not Eligible X-Failure to Comply	Required if Program End Date field completed.
Program	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	59	94	Blank fill	CASEWORKER departments only
Program	End of Record Marker		alphanumeric	1		95	95	Must contain '|'	
Supervision	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Supervision	Personal ID Number	Child's Personal ID Number (PID).	numeric	7	9999999	4	10	0000001..9999999	
Supervision	Referral Number	Specifies the referral for which this supervision applies.	numeric	7	9999999	11	17	0000001..9999999	
Supervision	Record Type	Record identifier for Supervision Record.	alphanumeric	2		18	19	"SV"	
Supervision	Supervision Sequence Number	Uniquely identifies this Supervision record from all other supervision records for the specified Personal ID Number.	numeric	6	999999	20	25	000001..999999	Used in conjunction with the PID Number and Referral Number to determine unique supervision event. Once assigned it should not be changed.
Supervision	Supervision Type	Specifies the type of supervision. Definitions of these categories are available on the TJPC website.	alphanumeric	4	left-justify, blank fill	26	29	PROB-Court Ordered Probation DEFP-Deferred Prosecution CREL-Conditional Release from Detention TEMP-Temporary Pre-Court Monitoring INDR-Indirect Supervision PRBI-Interim Probation PRBP-Permanent Probation (Transferred) IICT-Inter-county Transfer Supervision DEFI-Interim Deferred Prosecution	
Supervision	Supervision Begin Date	The beginning date of the supervision.	numeric	8	YYYYMMDD	30	37	Valid date between 1/1/1900 and 12/31/2099.	
Supervision	Supervision Expected End Date	The date that the supervision is scheduled to end (based on a court order or department agreement).	numeric	8	YYYYMMDD	38	45	Valid date between 1/1/1900 and 12/31/2099 and greater than or equal to the Supervision Begin Date.	
Supervision	Supervision End Date	The ending date of the supervision.	numeric	8	YYYYMMDD	46	53	Valid date between 1/1/1900 and 12/31/2099 and greater than or equal to the Supervision Begin Date. Zero fill if not applicable.	
Supervision	Supervision Outcome	Specifies the supervision outcome. Definitions of these categories are available on the TJPC website.	alphanumeric	1		54	54	S-Completed A-Transferred to the Adult System B-Absent without Permission D-Deceased J-Transferred out of Jurisdiction T-TYC Commitment X-Failure to Comply	Required if Supervision End Date field completed.
Supervision	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	55	90	Blank fill	CASEWORKER departments only
Supervision	End of Record Marker		alphanumeric	1		91	91	Must contain '|'	
Delete	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Delete	FILLER		alphanumeric	14		4	17	Blank fill	
Delete	Record Type	Record identifier for Delete Record.	alphanumeric	2		18	19	"XX"	
Delete	Delete Record Type	**A Delete Record should only be used to remove records reported in error. It should <u>not</u> be used to remove sealed or purged records.** A request to delete a Child Record will cause all records for the specified PID Number to be removed. A request to delete a Referral Record will cause all records attached to the referral (i.e. detentions, offenses, placements, etc) to be removed. All other delete requests will remove only the requested record.	alphanumeric	2		20	21	01-Child 03-Referral DN-Detention MA-MAYSI BH-Behavioral Health OF-Offense PL-Placement PG-Program SV-Supervision	
Delete	Delete Personal ID Number	Specifies the personal identification number of the record to be deleted.	numeric	7	9999999	22	28	0000001..9999999	Required for all delete transactions.
Delete	Delete Referral Number	Specifies the referral number of the record to be deleted.	numeric	7	9999999	29	35	0000001..9999999, zero fill if not applicable	Required for all delete transactions except '01'-Child and 'BH'-Behavioral Health.
Delete	Delete Sequence Number	Specifies the sequence number of the record to be deleted.	numeric	6	999999	36	41	000001..999999, zero fill if not applicable	Required for all delete transactions except '01'-Child and '03'-Referral.

Record Specifications:

Record Type	Field Name	Description	Type	Size	Format	Begin Column	End Column	Edit Criteria	Dependencies
Delete	CASEWORKER Record ID	Unique record identifier assigned by CASEWORKER.	alphanumeric	36	left-justify, blank fill	42	77	Blank fill	CASEWORKER departments only
Delete	End of Record Marker		alphanumeric	1		78	78	Must contain ']'	

Trailer	Headquarter County Number	County where department headquarters is located.	numeric	3	999	1	3	001..254	
Trailer	FILLER		alphanumeric	14		4	17	"ZZZZZZZZZZZZZZ"	Must be last record in the file.
Trailer	Record Type	Record identifier for Trailer Record.	alphanumeric	2		18	19	"ZZ"	
Trailer	Total Record Count	Total number of records contained in the file including the header and trailer.	numeric	8	99999999	20	27		Compared to calculated number of records to ensure complete file was transmitted.
Trailer	End of Record Marker		alphanumeric	1		28	28	Must contain ']'	

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas State Affordable Housing Corporation

Notice of the Implementation of a 2009 Qualified Mortgage Credit Certificate Program

The Texas State Affordable Housing Corporation (the "Corporation"), a nonprofit corporation organized under the laws of the State of Texas (the "Program Area"), is implementing a qualified mortgage credit certificate program (the "Program") within the Program Area to assist eligible purchasers. A Mortgage Credit Certificate ("MCC") is an instrument designed to assist persons better afford home ownership. The MCC Program allows first-time homebuyers an annual federal income tax credit equal to the lesser of $2,000 or the credit rate for the MCC multiplied by the amount of interest paid by the holder on a home mortgage loan during each year that they occupy the home as their principal residence.

An eligible purchaser of a residence located within a Program Area may apply to the Corporation for an MCC through a participating lender of his or her choice at the time of purchasing a principal residence and obtaining a mortgage loan from a participating lender. To be an eligible purchaser to receive an MCC, a purchaser must meet the following criteria:

(1) Be one of the following:

(a) A household whose annual income does not exceed 80% Area Median Family Income (AMFI); or

(b) A full-time Texas classroom teacher, teacher's aide, school librarian, school nurse, school counselor, or an allied health or nursing faculty member; or

(c) A full-time paid fire fighter, peace officer, corrections officer, juvenile corrections officer, county jailer, EMS personnel, or public security officer, working in the State of Texas.

(2) The applicant for the MCC cannot have had an ownership interest in his or her principal residence during the three-year period ending on the date the mortgage loan is obtained.

(3) The applicant must intend to occupy the residence with respect to which the MCC is obtained as his or her principal residence within 60 days after the MCC is issued. The MCC issued to an applicant will be revoked if the residence to which the MCC relates ceases to be occupied by the applicant as his or her principal residence.

(4) The MCC cannot be issued to an applicant in conjunction with the replacement or refinancing of an existing mortgage loan. The MCC can, however, be obtained in conjunction with the replacement of a construction period or bridge loan having a term of less than 24 months.

(5) Federal law imposes limitations on the purchase price of homes financed under the program. The current maximum purchase price for a one-family home in a non-targeted area is $237,031 and for a one-family home in a targeted area is $289,705. These limitations are periodically adjusted. Two-family, three-family and four-family residences are also eligible, provided that one of the units will be occupied by the mortgagor as his or her principal residence and that the residence was first occupied for residential purposes at least five years prior to the closing of the mortgage. The cost of the residence must not exceed the maximum purchase price limits. The purchase price limitation does not apply to qualified home improvement loans. There are special rules that apply to qualified rehabilitation loans.

(6) Additionally, an applicant's current annualized family income may not exceed 80% of the AMFI if the eligible purchaser is a purchaser listed under (1)(a) above or the greater of 115% of the AMFI adjusted for family size or the maximum amount permitted by Section 143(f) of the Internal Revenue Code of 1986 if the purchaser is a purchaser listed under (1)(b) or (1)(c) above. Visit www.tsahc.org to view the maximum incomes allowed.

Anyone receiving an MCC and selling his or her residence within nine years of the issuance of the MCC may be required to return all or a portion of the tax credit received in connection therewith to the Internal Revenue Service.

To defray the costs of implementing the Program, the Corporation will charge applicants a $100 application fee, a $250 closing package review fee, plus an MCC issuance fee equal to one percent of the amount of such person's loan.

The Corporation strongly encourages anyone who believes that he or she qualifies for an MCC to apply at the offices of a participating lender. For more information regarding the Program and its restrictions, including a list of current participating lenders, please contact the Paige McGilloway, Single Family Programs Manager, at (888) 638-3555 or by email at pmcgilloway@tsahc.org.

TRD-200900235
David Long
President
Texas State Affordable Housing Corporation
Filed: January 20, 2009

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Office of the Attorney General

Notice of Amendment and Extension to a Major Consulting Contract

The Office of the Attorney General of Texas (OAG) announces the amendment and extension of contract #08-C0074 with Deloitte Consulting, LLP, an entity with a principal place of business at 400 West 15th Street, Suite 1700, Austin, Texas 78701. Under the amended and extended contract, the contractor will provide "Development and Continuity Assurance" by creating detailed project plans and requirements for the OAG approved projects, as well as the continuity necessary from the previous contract terms to enable the OAG to achieve its vision. The contractor will also establish the technical and procedural infrastructure necessary to implement the approved recommendations.

The total value of the contract amendment will not exceed $7,318,325. The contract has been extended to August 31, 2009, unless extended or terminated sooner by the OAG. The contractor must complete and submit all deliverables under the contract to the OAG by August 31, 2009. The contract includes an OAG option for up to a four calendar month extension that can be exercised at OAG's sole discretion.

For more information regarding this publication, contact Cindy Hodges, Agency Liaison, at (512) 936-1841.

TRD-200900264
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: January 21, 2009

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.009, and 304.003, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 01/26/09 - 02/01/09 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 01/26/09 - 02/01/09 is 18% for Commercial over $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 02/01/09 - 02/28/09 is 5.00% for Consumer/Agricultural/Commercial/credit through $250,000.

The judgment ceiling as prescribed by §304.003 for the period of 02/01/09 - 02/28/09 is 5.00% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

TRD-200900244
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: January 21, 2009

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Credit Union Department

Application to Amend Articles of Incorporation

Notice is given that the following application has been filed with the Credit Union Department and is under consideration:

An application for a name change was received from Corpus Christi City Employees Credit Union, Corpus Christi, Texas. The credit union is proposing to change its name to Corpus Christi Community Credit Union.

Comments or a request for a meeting by any interested party relating to an application must be submitted in writing within 30 days from the date of this publication. Any written comments must provide all information that the interested party wishes the Department to consider in evaluating the application. All information received will be weighed during consideration of the merits of an application. Comments or a request for a meeting should be addressed to the Texas Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699.

TRD-200900237
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 21, 2009

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Applications to Expand Field of Membership

Notice is given that the following applications have been filed with the Credit Union Department (Department) and are under consideration:

An application was received from First Service Credit Union, Houston, Texas to expand its field of membership. The proposal would permit employees of Rodriguez Chavez Corporation dba RCH Industries who work in or are paid from Houston, Texas, to be eligible for membership in the credit union.

An application was received from Associated Credit Union of Texas, Deer Park, Texas to expand its field of membership. The proposal would permit persons who work or reside within a 10-mile radius of the following ACUTX branch location: 3550 Spencer Highway, Pasadena, TX 77505, to be eligible for membership in the credit union.

An application was received from Pioneer Muslim Credit Union, Houston, Texas to amend its field of membership. The proposal would permit any Ismaili Muslim who can demonstrate heritage as a Momin originating in Sidhpur, Gujarat, India, and its surrounding areas, and is a member of the Shia Imami Ismaili Muslims Jamatkhana in Houston, Texas or who lives, works, worships or attends school within ten (10) miles of the credit union office at 5555 North Lamar, Austin, Texas 78751, including all other members who are not a Momin as of the date of this amendment; any business or organization whose owners or employees are within this field of membership; and members of the family of such persons as specified by the Board of Directors in written policy, to be eligible for membership in the credit union.

Comments or a request for a meeting by any interested party relating to an application must be submitted in writing within 30 days from the date of this publication. Credit unions that wish to comment on any application must also complete a Notice of Protest form. The form may be obtained by contacting the Department at (512) 837-9236 or downloading the form at http://www.tcud.state.tx.us/applications.html. Any written comments must provide all information that the interested party wishes the Department to consider in evaluating the application. All information received will be weighed during consideration of the merits of an application. Comments or a request for a meeting should be addressed to the Texas Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699.

TRD-200900238
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 21, 2009

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Notice of Final Action Taken

In accordance with the provisions of 7 TAC §91.103, the Credit Union Department provides notice of the final action taken on the following application:

Application to Expand Field of Membership--Approved

Auto Parts Employees Credit Union, Fort Worth, Texas--See *Texas Register* issue dated October 31, 2008.

TRD-200900236
Harold E. Feeney
Commissioner
Credit Union Department
Filed: January 21, 2009

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Texas Education Agency

Request for Applications Concerning Texas 21st Century Community Learning Centers, Cycle 6, Year 1, Grant Application

Eligible Applicants. The Texas Education Agency (TEA) is requesting applications under Request for Applications (RFA) #701-09-103 from local educational agencies (LEAs), including public school districts, open-enrollment charter schools, and regional education service centers; community-based organizations (CBOs); and other public or private entities, nonprofit or for profit, or a consortium of two or more agencies, organizations, or entities to establish or expand community learning centers. Examples of agencies and organizations eligible under the Texas 21st Century Community Learning Centers Grant Program include, but are not limited to, nonprofit agencies, city or county government agencies, faith-based organizations, institutions of higher education, and for-profit corporations. A shared services arrangement (SSA) of two or more LEAs is also eligible to apply.

Description. The purpose of the Texas 21st Century Community Learning Centers Grant Program, Cycle 6, Year 1, is to provide opportunities beyond the normal school day for communities to establish or expand activities in community learning centers that (1) provide opportunities for academic enrichment, including providing tutorial services to help children, particularly students who attend low-performing schools, meet state and local student academic achievement standards in core academic subjects such as reading and mathematics; (2) offer students a broad array of additional services, programs, and activities such as youth development activities; drug and violence prevention programs; counseling programs; art, music, and physical education and fitness programs; and technology education programs that are designed to reinforce and complement the regular academic program of participating students; and (3) offer families of students served by community learning centers opportunities for literacy and related educational development. Program services must be offered only when schools are not in session (before or after school, during holidays, or during summer recess). The program must be carried out in active collaboration with the schools the students attend. Applications must provide for partnerships between an LEA, a CBO, and other public or private organizations, if appropriate.

Dates of Project. The Texas 21st Century Community Learning Centers Grant Program, Cycle 6, Year 1, will be implemented during the 2009-2010 school year. Applicants should plan for a starting date of no earlier than August 1, 2009, and an ending date of no later than July 31, 2010.

Project Amount. Funding will be provided for approximately 25-30 projects. Each project will receive a maximum of $200,000 for the 2009-2010 project period. This project is funded 100 percent from 21st Century Community Learning Center federal funds.

Selection Criteria. Applications will be selected based on the ability of each applicant to carry out all requirements contained in the RFA. Reviewers will evaluate applications based on the overall quality and validity of the proposed grant programs and the extent to which the applications address the primary objectives and intent of the project. Applications must address each requirement as specified in the RFA to be considered for funding. TEA reserves the right to select from the highest-ranking applications those that address all requirements in the RFA.

TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TEA to pay any costs before an application is approved. The issuance of this RFA does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Applicant's Conference. Prospective applicants will be provided an opportunity to receive general and clarifying information from the TEA about the scope of this RFA on Monday, March 2, 2009, from 1:00 p.m. until 3:00 p.m. on the Texas Education Telecommunication Network (TETN). This applicant's conference/TETN session will be the only opportunity, in a group setting, to ask clarifying questions of TEA staff to assist potential applicants in clarifying their understanding of the scope and nature of the work required in this application. The conference will be open to all potential applicants, and all questions asked and answered will be in the presence of all attending. Pre-conference questions may be sent to james.connolly@tea.state.tx.us prior to Friday, February 27, 2009. Each person attending will be required to sign a register setting out the representative's name and the name, address, and telephone number of the applicant organization represented. The entire applicant's conference will be digitally recorded and streamed over the Internet. Prospective applicants who are not able to attend the applicant's conference may request a password and procedures to download the video stream from the TETN site manager at their local education service center (ESC). A complete list of ESCs, including contact information, is available on the TEA website at http://ritter.tea.state.tx.us/ESC/.

Requesting the Application. Due to the high cost of printing and mailing RFAs, they will no longer be available in print. The announcement letter and complete RFA will be posted on the TEA website at http://burleson.tea.state.tx.us/GrantOpportunities/forms for viewing and downloading. In the "Select Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view all documents that pertain to this RFA.

Further Information. For clarifying information about the RFA, contact James Connolly, Division of Discretionary Grants, Texas Education Agency, (512) 463-9269. In order to assure that no prospective applicant may obtain a competitive advantage because of acquisition of information unknown to other prospective applicants, any information that is different from or in addition to information provided in the RFA will be provided only in response to written inquiries. Copies of all such inquiries and the written answers thereto will be posted on the TEA website in the format of Frequently Asked Questions (FAQs) at http://burleson.tea.state.tx.us/GrantOpportunities/forms. In the "Select Search Options" box, select the name of the RFA from the drop-down list. Scroll down to the "Application and Support Information" section to view all documents that pertain to this RFA.

Deadline for Receipt of Applications. Applications must be received in the TEA Document Control Center by 5:00 p.m. (Central Time), Tuesday, April 14, 2009, to be eligible to be considered for funding.

TRD-200900242
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: January 21, 2009

Request for Proficiency Tests for the Assessment of Limited English Proficient Students

Description. The Texas Education Agency (TEA) is notifying assessment publishers that proficiency assessments and/or achievement tests may be submitted for review for the *List of State Approved Tests for the Assessment of Limited English Proficient Students.* Texas Education Code (TEC), §29.056(a)(2), authorizes TEA to compile a list of

approved assessments for the purposes of identifying students as limited English proficient for entry into or exit (when appropriate) from bilingual education and/or English as a second language (ESL) programs; annually assessing oral language proficiency in English and Spanish when required; and measuring reading and writing proficiency in English and Spanish for program placement. The state-approved tests placed on the list must be based on scientific research and must measure oral language proficiency in listening and speaking in English and Spanish from Prekindergarten (PK)-Grade 12. Assessments must also measure reading and writing in English and Spanish from PK-Grade 12. Reading and writing assessments indicate placement in the bilingual/ESL program and are not for entry purposes.

Norm-referenced standardized achievement tests in English will be used for identification, entry into, and exit (only for Grades 1 and 2) from programs and may be used for formative assessments.

Norm-referenced standardized achievement tests in Spanish may be used for placement purposes only. All tests to be included on the *List of State Approved Tests for the Assessment of Limited English Proficient Students* must be re-normed every six years to meet the criteria specified in TEC, §39.032, which requires that standardization norms not be more than six years old at the time the test is administered. The 2009-2010 *List of State Approved Tests for the Assessment of Limited English Proficient Students* will be in effect only for the 2009-2010 school year. Assessments currently on the list of approved tests must be resubmitted only if they contain the stipulation on the current list that they cannot be used after 2008-2009. New assessments that meet the specified criteria must be submitted for evaluation at this time.

The Assessment Committee, comprised of stakeholders from throughout the state and TEA staff, will review and approve the 2009-2010 *List of State Approved Tests for the Assessment of Limited English Proficient Students.* The Assessment Committee may choose to change the criteria and/or effective dates at a future time.

Selection Criteria. Assessment publishers will be responsible for submitting tests that they wish to be reviewed for consideration for inclusion on the 2009-2010 *List of State Approved Tests for the Assessment of Limited English Proficient Students.* All tests submitted for review must be based on scientific research and must measure oral language proficiency in listening and speaking in English and Spanish from PK-Grade 12. Assessments must measure reading and writing in English and Spanish from PK-Grade 12 and must meet the state criteria for reliability and validity. Therefore, technical manuals must also be submitted and must be available for the review of assessments to be held on February 27, 2009. Assessments must also measure specific proficiency levels in oral language, reading, and writing in both English and Spanish. Assessment instruments (English and Spanish) submitted for review will be grouped in the following categories: (1) Oral Language Proficiency Tests in English in Listening and Speaking domains; (2) Oral Language Proficiency Tests in Spanish in Listening and Speaking domains; (3) Reading and Writing Proficiency in English; (4) Reading and Writing Proficiency in Spanish; and (5) Ability Tests/Gifted and Talented. Publishers are not required to submit proposals for all categories.

Proposals must be submitted and presented on February 27, 2009, to be considered for inclusion on the *List of State Approved Tests for the Assessment of Limited English Proficient Students.* Assessment publishers will be required to attend the review of the assessments on February 27, 2009, which will be held at the William B. Travis Building, Room G-100, PDC7, 1701 North Congress Avenue, Austin, Texas. Complete official sample test copies in English and Spanish with comprehensive explanations, including (1) scoring information; (2) norming data information, including ethnicity, gender, grade level, and geographic region; and (3) technical manuals with validity and reliability information, must be presented at that time. Only materials presented on February 27, 2009, will be considered for approval. Publishers must be available all day at the request of the committee, and must make arrangements to pick up all materials at the end of the day. Any materials and/or revisions submitted after the deadline cannot be reviewed until the following year.

Further Information. For clarifying information, contact Georgina Gonzalez, Director of Bilingual/ESL, or Susie Coultress, Assistant Director of Bilingual/ESL, Texas Education Agency, (512) 463-9581.

TRD-200900240
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: January 21, 2009

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **March 2, 2009**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on March 2, 2009**. Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing**.

(1) COMPANY: Adrian Balderas dba AB Builders; DOCKET NUMBER: 2008-1972-WQ-E; IDENTIFIER: RN105629711; LOCATION: Tom Green County; TYPE OF FACILITY: home builder; RULE VIOLATED: 30 Texas Administrative Code (TAC) §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $700; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 78903-7035, (325) 655-9479.

(2) COMPANY: Maximino Acuna III; DOCKET NUMBER: 2008-1963-WOC-E; IDENTIFIER: RN103454641; LOCATION: San Patricio County; TYPE OF FACILITY: water operator; RULE VIO-

LATED: 30 TAC §30.5(a), by failing to obtain a required occupational license; PENALTY: $210; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(3) COMPANY: Allen Keller Company; DOCKET NUMBER: 2008-1965-WQ-E; IDENTIFIER: RN105657522; LOCATION: Gillespie County; TYPE OF FACILITY: construction company; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $700; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(4) COMPANY: Brazier Construction Inc.; DOCKET NUMBER: 2008-1962-WQ-E; IDENTIFIER: RN105644439; LOCATION: Jack County; TYPE OF FACILITY: construction company; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $700; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(5) COMPANY: Briarwood Lutheran Ministries; DOCKET NUMBER: 2008-1421-MWD-E; IDENTIFIER: RN102362498; LOCATION: Denton County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(17), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0012605002, Sludge Provisions, by failing to timely submit the annual sludge reports; 30 TAC §319.7(c) and TPDES Permit Number WQ0012605002, Monitoring and Reporting Requirements Number 1, by failing to timely complete and submit discharge monitoring reports; 30 TAC §305.125(4), TPDES Permit Number WQ0012605002, Permit Conditions Number 2.d., and the Code, §26.121(a), by failing to prevent an unauthorized discharge of sludge; 30 TAC §217.330(a) (formerly 30 TAC §317.4(a)(8)), by failing to provide an approved backflow prevention device between the public drinking water supply and the wastewater treatment facility; and 30 TAC §305.125(1) and TPDES Permit Number WQ0012605002, Monitoring and Reporting Requirements Number 5, by failing to calibrate all flow measuring devices; PENALTY: $6,025; ENFORCEMENT COORDINATOR: Merrilee Hupp, (512) 239-4490; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(6) COMPANY: City of Bridgeport; DOCKET NUMBER: 2008-1747-MWD-E; IDENTIFIER: RN102740230; LOCATION: Wise County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0010389002, Effluent Limitations and Monitoring Requirements Numbers 1, 2, and 6, and the Code, §26.121(a), by failing to comply with permitted effluent limitations for ammonia nitrogen, dissolved oxygen, and chlorine; and 30 TAC §305.125(17) and TPDES Permit Number WQ0010389002, Sludge Provisions, by failing to timely submit monitoring results at the intervals specified in the permit; PENALTY: $4,795; ENFORCEMENT COORDINATOR: Tom Jecha, (512) 239-2576; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(7) COMPANY: Costco Wholesale Corporation dba Costco Gasoline Station 636; DOCKET NUMBER: 2008-1677-PST-E; IDENTIFIER: RN104959697; LOCATION: Dallas County; TYPE OF FACILITY: wholesale store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and Texas Health and Safety Code (THSC), §382.085(b), by failing to verify proper operation of the Stage II equipment; PENALTY: $5,601; ENFORCEMENT COORDINATOR: Michael Pace, (817) 588-5800; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(8) COMPANY: City of Del Rio; DOCKET NUMBER: 2008-1575-MLM-E; IDENTIFIER: RN101264299; LOCATION: Val Verde County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.41(c)(1)(F), by failing to secure a sanitary control easement; 30 TAC §290.46(m), by failing to ensure the good working condition and general appearance of the facility and its equipment; and 30 TAC §288.30(5)(B), by failing to submit a drought contingency plan; PENALTY: $755; ENFORCEMENT COORDINATOR: Christopher Keffer, (512) 239-5610; REGIONAL OFFICE: 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

(9) COMPANY: E. E. Hood & Sons, Inc.; DOCKET NUMBER: 2008-1746-EAQ-E; IDENTIFIER: RN105522668; LOCATION: Uvalde County; TYPE OF FACILITY: limestone quarry; RULE VIOLATED: 30 TAC §213.4(a)(1), by failing to obtain approval of a Edwards Aquifer water pollution abatement plant; PENALTY: $33,750; ENFORCEMENT COORDINATOR: Lauren Smitherman, (512) 239-5223; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(10) COMPANY: Elvan Management, Inc. dba Elvan's Granbury Chevron; DOCKET NUMBER: 2008-1443-PST-E; IDENTIFIER: RN102445491; LOCATION: Hood County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.7(d)(3), by failing to provide an amended underground storage tank (UST) registration; 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and the Code, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate; 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to ensure that all USTs are monitored in a manner which will detect a release; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide release detection for the piping associated with the USTs; and 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records; PENALTY: $6,498; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(11) COMPANY: Extrusion Plus LLC; DOCKET NUMBER: 2008-1493-AIR-E; IDENTIFIER: RN105558878; LOCATION: Harris County; TYPE OF FACILITY: plant that extrudes high-performance polymer tubing; RULE VIOLATED: 30 TAC §116.110(a)(1) and THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization before operation of facilities which may emit air contaminants into the atmosphere; PENALTY: $5,000; ENFORCEMENT COORDINATOR: Carlie Konkol, (361) 825-3100; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(12) COMPANY: Formosa Plastics Corporation, Texas; DOCKET NUMBER: 2008-1412-AIR-E; IDENTIFIER: RN100218973; LOCATION: Calhoun County; TYPE OF FACILITY: inorganic chemical plant; RULE VIOLATED: 30 TAC §101.20(3) and §116.115(c), Air Permit Numbers 19871 and PSD-TX-760M7, Special Condition (SC) Numbers 1 and 7, and THSC, §382.085(b), by failing to route displaced vapors from the marine loading of ethylene dichloride to the dock incinerator/scrubber; PENALTY: $7,425; Supplemental Environmental Project (SEP) offset amount of $2,970 applied to City of Point Comfort-Wastewater Treatment Plant Repair Assistance; ENFORCEMENT COORDINATOR: Suzanne Walrath, (512) 239-2134; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100

(13) COMPANY: City of Kirbyville; DOCKET NUMBER: 2007-1599-MLM-E; IDENTIFIER: RN102186053; LOCATION: Jasper County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(5) and TPDES Permit Number WQ0014384001, Operational Requirements Number 1, by failing to properly operate and maintain all systems of treatment and control; 30 TAC §319.1 and TPDES Permit Number WQ0014384001, Monitoring and Reporting Requirements Number 1, by failing to correctly report analytical data on discharge monitoring reports; 30 TAC §319.11(a) and TPDES Permit Number WQ0014384001, Monitoring and Reporting Requirements Number 2, by failing to comply with test procedures for analyses of pollutants; 30 TAC §305.125(9) and TPDES Permit Number WQ0014384001, Monitoring and Reporting Requirements Number 7.a., by failing to provide noncompliance notification to the TCEQ for unauthorized discharges; 30 TAC §305.125(4), TPDES Permit Number WQ0014384001, Permit Conditions Number 2(g), and the Code, §26.121(a), by failing to prevent the unauthorized discharge of wastewater; 30 TAC §330.15, by failing to prevent the unauthorized discharge of wastewater generated from washing out garbage trucks; the Code, §26.121(a) and TPDES Permit Number WQ0014384001, Permit Conditions Number 2(g), by failing to prevent the unauthorized discharge of wastewater into or adjacent to water in the state; and 30 TAC §305.125(5) and TPDES Permit Number WQ0014384001, Operational Requirements Number 1, by failing to properly operate and maintain all systems of treatment and control; PENALTY: $29,470; ENFORCEMENT COORDINATOR: Pamela Campbell, (512) 239-4493; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(14) COMPANY: City of Magnolia; DOCKET NUMBER: 2008-1289-MWD-E; IDENTIFIER: RN101919769: LOCATION: Montgomery County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.65 and §305.125(2) and the Code, §26.121(a)(1), by failing to maintain authorization for the discharge of wastewater; PENALTY: $8,520; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(15) COMPANY: Gerard Ortiz dba River Oaks Water System; DOCKET NUMBER: 2008-1287-PWS-E; IDENTIFIER: RN101189348; LOCATION: Burnet County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.46(s), by failing to provide accurate testing equipment; 30 TAC §290.46(m)(1)(A), by failing to perform annual inspection of the system's ground storage tanks; 30 TAC §290.46(m)(1)(B), by failing to perform annual inspection of the system's pressure tank; 30 TAC §290.42(1), by failing to compile and maintain a complete and up-to-date operations manual for operator review and reference; 30 TAC §290.46(f)(3), (3)(A)(i)(III), (ii)(III), (iii) - (vi), by failing to develop and maintain a record of water works activities and maintenance activities; 30 TAC §290.46(u), by failing to plug abandoned public water supply wells with cement; 30 TAC §290.43(d)(3), by failing to provide the pressure tank with facilities for maintaining the air-water-volume at the design water level and working pressure and by failing to equip the air injection line with filters or other devices to prevent compressor lubricants and other contaminants from entering the pressure tank; 30 TAC §290.41(c)(3)(N), by failing to provide an operational flow measuring device for the water system's well; 30 TAC §290.46(e)(4)(A) and THSC, §341.033(a), by failing to operate the water system under the direct supervision of a water works operator who holds a Class "D" or higher license; and 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the system's facilities and equipment; PENALTY: $3,119; ENFORCEMENT COORDINATOR: Andrea Linson-Mgbeoduru, (512) 239-1482; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(16) COMPANY: Thomas V. Rodriquez; DOCKET NUMBER: 2008-1961-WOC-E; IDENTIFIER: RN103414322; LOCATION: Haskell County; TYPE OF FACILITY: water operator; RULE VIOLATED: 30 TAC §30.5(a), by failing to obtain a required occupational license; PENALTY: $210; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(17) COMPANY: Texas Petrochemicals LP; DOCKET NUMBER: 2008-0391-AIR-E; IDENTIFIER: RN100219526; LOCATION: Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §116.115(c), Air Permit Number 46307, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; 30 TAC §101.201(b)(1)(H) and THSC, §382.085(b), by failing to include the permit number on the incident report; and 30 TAC §101.201(a)(1)(B) and THSC, §382.085(b), by failing to submit an initial notification; PENALTY: $62,369; SEP offset amount of $24,948 applied to Harris County Public Health and Environmental Services-Pollution Control Division's Fourier Transform Infra Red Project; ENFORCEMENT COORDINATOR: John Muennink, (361) 825-3100; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(18) COMPANY: Tiger Glenn Apartments, Inc.; DOCKET NUMBER: 2008-1498-PST-E; IDENTIFIER: RN101759371; LOCATION: Nueces County; TYPE OF FACILITY: inactive UST; RULE VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed implementation date, one UST; and 30 TAC §334.54(b)(2), by failing to maintain all piping, pumps, manways, tank access points, and ancillary equipment in a capped, plugged, locked, and/or otherwise secured manner to prevent access, tampering, or vandalism; PENALTY: $2,625; ENFORCEMENT COORDINATOR: Steven Lopez, (512) 239-1896; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(19) COMPANY: John D. Walden, Jr.; DOCKET NUMBER: 2008-1960-WOC-E; IDENTIFIER: RN103516266; LOCATION: Jack County; TYPE OF FACILITY: water operator; RULE VIOLATED: 30 TAC §30.5(a), by failing to obtain a required occupational license; PENALTY: $210; ENFORCEMENT COORDINATOR: Melissa Keller, (512) 239-1768; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(20) COMPANY: Westphalia Water & Sewer Supply Corporation; DOCKET NUMBER: 2008-0598-MWD-E; IDENTIFIER: RN103930061; LOCATION: Falls County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number 14382001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to comply with the daily average concentration of 30 milligrams per liter and the daily average loading limit of five pounds per day for biochemical oxygen demand; PENALTY: $7,245; ENFORCEMENT COORDINATOR: Trina Grieco, (210) 490-3096; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

TRD-200900223
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 20, 2009

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Notice of Opportunity to Request a Public Meeting for a New Municipal Solid Waste Transfer Station - Registration Application Number 40240

APPLICATION. City of Kerrville, 800 Junction Highway, Kerrville, Texas 78028, has applied to the Texas Commission on Environmental Quality (TCEQ) for proposed Registration No. 40240, to construct and operate a Type V municipal solid waste transfer station. The proposed facility, Kerrville Transfer Station will be located approximately 2.5 miles southeast of the intersection of State Highways 27 and 16, in Kerr County. This facility is requesting authorization to transfer municipal solid waste which includes municipal solid waste, construction and demolition waste, commercial waste, industrial Class 2 and Class 3 waste, yard waste, brush and similar materials, rubbish, incidental amounts of special wastes, and tires. The registration application is available for viewing and copying at the TCEQ Region 13 Office, 14250 Judson Road, San Antonio, Texas 78233-4480 and may be viewed online at http://www.kerrville.org/index.asp?nid=78.

PUBLIC COMMENT/PUBLIC MEETING. Written public comments or written requests for a public meeting must be submitted to the Office of Chief Clerk at the address included in the information section below. Comments may also be received if a public meeting is held on the facility. A public meeting will be held by the executive director if requested by a member of the legislature who represents the general area where the development is to be located, or if there is a substantial public interest in the proposed development. The purpose of the public meeting is for the public to provide input for consideration by the commission, and for the applicant and the commission staff to provide information to the public. A public meeting is not a contested case hearing. The executive director will review and consider public comments and written requests for a public meeting submitted prior to the notice of final determination. The executive director is not required to file a response to comments.

EXECUTIVE DIRECTOR ACTION. The executive director shall, after review of an application for registration, determine if the application will be approved or denied in whole or in part. If the executive director acts on an application, the chief clerk shall mail or otherwise transmit notice of the action and an explanation of the opportunity to file a motion to reconsider the executive director's decision. The chief clerk shall mail this notice to the owner and operator, the public interest counsel, to adjacent landowners as shown on the required land ownership map and landowners list, and to other persons who timely filed public comment in response to public notice. Not all persons on the mailing list for this notice will receive the notice letter from the Office of the Chief Clerk.

INFORMATION. Written public comments or requests to be placed on the permanent mailing list for this application should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-30887 or electronically submitted to http://www5.tceq.state.tx.us/rules/ecomments/. Individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.state.tx.us. Further information may also be obtained from the City of Kerrville at the address stated above or by calling Mr. Gregory J. Lewis, P.E., Vice President, Associated Consulting Engineers, Inc. at (512) 329-0006.

TRD-200900263
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: January 21, 2009

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Notice of Water Quality Applications

The following notices were issued during the period of December 11, 2008 through January 16, 2009.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

3 B AND J WASTEWATER COMPANY INC has applied to the Texas Commission on Environmental Quality (TCEQ) for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014911001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 950,000 gallons per day. The facility will be located approximately 2,400 feet northwest of the intersection of County Road 248 and Westridge Lane in Williamson County, Texas.

AQUA WATER SUPPLY CORPORATION has applied for a major amendment to TPDES Permit No. WQ0014225001 to authorize an increase in the discharge of water treatment filter backwash wastewater from a daily average flow not to exceed 8,850 gallons per day to a daily average flow not to exceed 27,000 gallons per day. The facility is located on State Highway 95, approximately 2.8 miles south of the US Highway 290 and State Highway 95 intersection in the City of Elgin in Bastrop County, Texas.

AUC GROUP LP has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014909001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 50,000 gallons per day. The facility will be located approximately 500 feet west of the intersection of Miller Road and Farm-to-Market Road 2978 in Montgomery County, Texas.

BROWNSVILLE PUBLIC UTILITIES BOARD has applied for a major amendment to TPDES Permit No. WQ0010397003 to remove: restrictions on sludge disposal during wet conditions, the minimum required solids content of 15% prior to sludge disposal and the sludge disposal limit of 20 dry tons/acre/year from the permit. The current permit authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 12,800,000 gallons per day. The current permit also authorizes the disposal of sewage sludge at Brownsville Public Utilities Board Sludge Only Dedicated Land Disposal (DLD) site, TPDES Permit No. WQ0010397003, in Cameron County. The facility is located at 2800 East Avenue, north of the 2800 block of East Avenue, approximately 1/2 mile west of 30th Street in southeast Brownsville in Cameron County, Texas.

CEMEX CONSTRUCTION MATERIALS SOUTH LLC, has applied for a renewal of Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ00004636000 (EPA I.D. No. TXL005012) which authorizes the surface disposal of wastewater and water treatment plant sludge on approximately 192.84 acres of land used as a monofill area. The sludge disposal site is located approximately 30 miles east of the City of El Paso, approximately 5 1/4 miles northeast of the intersection of Hueco Ranch Road and U.S. Highway 62/180 in Hudspeth County, Texas.

CITY OF COLDSPRING has applied for a renewal of TPDES Permit No. WQ0013291001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 200,000 gallons per day. The facility is located approximately 1,500 feet south of the intersection of State Highway 150 and Farm-to-Market Road 2973 and

approximately 2,600 feet west of the intersection of State Highway 150 and Farm-to-Market Road 222 in San Jacinto County, Texas.

CITY OF FLATONIA has applied for a major amendment to TPDES Permit No. WQ0010101001, to increase the maximum pH level from 9.0 standard units to 10.0 standard units. The draft permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 250,000 gallons per day. The facility is located at 341 East I-10 Frontage Road approximately 500 feet north of Interstate Highway 10 and 1300 feet east of State Highway 95 on the north side of the City of Flatonia in Fayette County, Texas.

CITY OF GEORGETOWN has applied to the TCEQ for a renewal of TPDES Permit No. WQ0010489003, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,500,000 gallons per day. The facility is located at 400 Rock Dove Lane, approximately 1000 feet west of County Road 102; 4000 feet south of the intersection of State Highway 29 and County Road 102; and 2.75 miles east of the intersection of State Highway 29 and State Highway Spur 418 (South Austin Avenue) in the City of Georgetown in Williamson County, Texas.

CITY OF LULING has applied for a renewal of TPDES Permit No. WQ00110582001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 500,000 gallons per day. The facility is located approximately one-half (0.5) mile east of State Highway 80 and approximately one and one-half (1.5) miles south of the intersection of U.S. Highway 90 and State Highway 80 in Caldwell County, Texas.

CITY OF MEXIA has applied for a renewal of TPDES Permit No. WQ0010222001 which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,000,000 gallons per day. The facility is located approximately 0.5 mile south of the intersection of Travis Street and Bonham Street and approximately 1.25 miles southeast of the intersection of State Highway 14 and Farm-to-Market Road 39 in the City of Mexia in Limestone County, Texas.

CITY OF ROBINSON which operates the Robinson Water Treatment Plant, a potable water treatment facility, has applied for a major amendment to TPDES Permit No. WQ0003466000 to authorize less stringent effluent limits for total dissolved solids, chlorides, and sulfates at Outfall 001. The current permit authorizes the discharge of reverse osmosis unit reject stream at a daily average flow not to exceed 1,000,000 gallons per day via outfall 001. The facility is located at the southeast corner of intersection of 12th Street and Newland Drive in the extraterritorial jurisdiction of the City of Robinson, McLennan County, Texas.

COLETO CREEK POWER LP which operates the Coleto Creek Power Station, has applied for a major amendment without renewal to TPDES Permit No. WQ0002159000 to authorize an increase in the discharge of once-through cooling water from a daily average flow not to exceed 557,000,000 gallons per day to a daily average flow not to exceed 1,155,000,000 gallons per day via Outfall 001; an increase in the daily maximum flow not to exceed 560,000,000 gallons per day to a daily maximum flow not to exceed 1,210,000,000 gallons per day via Outfall 001; an increase in the effluent limitations for temperature at Outfall 001; recalculate mass loading effluent limitations for free available chlorine and total residual chlorine at Outfall 001; revision of the discharge description of once-through cooling water at Outfall 001; addition of new wastestreams via Outfall 003; addition of a new combustion byproduct storage leachate pond and to remove Other Requirements, Item 23 which references to an Aquaponics and a greenhouse. The current permit authorizes the discharge of once through cooling water at a daily average flow not to exceed 557,000,000 gallons per day via Outfall 001, treated domestic wastewater at a daily average flow not to exceed 10,000 gallons per day via Outfall 002, and ash transport water commingled with low volume waste and metal cleaning wastes on an intermittent and flow variable basis via Outfall 003. The facility is located adjacent to Coleto Creek Reservoir approximately 2.5 miles northeast of the Town of Fannin, Goliad County, Texas.

CW SCOA WEST LP has applied to the Texas Commission on Environmental Quality (TCEQ) for a minor amendment to TPDES Permit No. WQ0014740001, to revise the location description for the proposed facility. The existing permit shows the facility located 2,300 feet north of West Road and 600 feet west of Barker-Cypress Road in Harris County, Texas. The proposed revision will locate the facility 1,600 feet north of West Road and 3,100 feet west of Barker-Cypress Road in Northwest Harris County. The existing permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 320,000 gallons per day.

FEDERAL EMERGENCY MANAGEMENT AGENCY has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014934001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 33,750 gallons per day. The facility will be located approximately 4,000 feet north/northwest of the intersection of State Highway 124 and State Highway 87 in Galveston County, Texas. The TCEQ Executive Director has reviewed this action for consistency with the Texas Coastal Management Program goals and policies in accordance with the regulations of the Coastal Coordination Council, and has determined that the action is consistent with the applicable CMP goals and policies.

HERITAGE FINANCIAL GROUP INC has applied for a renewal of TPDES Permit No. WQ0012677001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day. The facility is located approximately 0.25 mile south of the intersection of Spencer Highway and Canada Street, 0.75 mile southwest of the intersection of Spencer Highway and Underwood Road in Harris County, Texas.

JIMMY DON PACK has applied for a Renewal of State Permit No. WQ0003563000, for a Concentrated Animal Feeding Operation (CAFO), to authorize the applicant to operate an existing dairy cattle facility at a maximum capacity of 450 head of which all are milking cows. The facility is located north of Highway 8, approximately 5 miles northwest of the intersection of State Highway 8 and Farm-to-Market Road 988 in Erath County, Texas.

K C UTILITIES INC has applied for a renewal of TPDES Permit No. WQ0012935001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 50,000 gallons per day. The facility is located approximately 3.2 miles north-northwest of the intersection of State Highway 6 and State Highway 35, adjacent to Brazoria County Road 144 to the west and to the east of Atchison, Topeka, and Santa Fe Railroad tracks in Brazoria County, Texas.

ROGER GLENN PACK for a Major Amendment, and conversion to an individual permit, of the Texas Pollutant Discharge Elimination System (TPDES) Registration No. WQ0003584000, for a Concentrated Animal Feeding Operation (CAFO), to authorize the applicant to operate an existing dairy cattle facility at a maximum capacity of 750 head, of which 750 head are milking cows. The applicant is also requesting to add new land application acreage located on the north side of County Road 456, approximately 0.4 mile east of the intersection of County Road 456 and County Road 430, said intersection is approximately 1.2 miles east of the intersection of County Road 430 and State Highway 108, approximately 5 miles south of Huckabay in Erath County, Texas. The facility is located approximately one mile east of the intersection of State Highway 108 and County Road 426, said intersection is lo-

cated approximately two miles south of the town of Huckabay in Erath County, Texas.

SYNAGRO OF TEXAS CDR INC has applied for a renewal of Permit No. WQ0004506000, which authorizes the land application of sewage sludge for beneficial use. The current permit authorizes land application of sewage sludge for beneficial use on 139 acres. This permit will not authorize a discharge of pollutants into waters in the State. The land application site is located 0.5 mile east of the intersection of Farm-to-Market Road 1305 and County Road 4225, approximately 5 miles north of the City of Poynor in Henderson County, Texas.

TEXAS AMERICAN WATER COMPANY has applied for a renewal of TPDES Permit No. WQ0012822001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 35,000 gallons per day. The facility is located approximately 2,300 feet south of County Road 128 and approximately 2,500 feet east of County Road 143 in Brazoria County, Texas.

THE CITY OF LORENA had applied for a major amendment to TPDES Permit No. WQ0012195001 to authorize an increase in the discharge of treated domestic wastewater from a daily average flow not to exceed 150,000 gallons per day to an annual average flow not to exceed 1,500,000 gallons per day. Subsequently, the permittee requested that the application be processed as a renewal of the existing permit. The existing permit authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 150,000 gallons per day. The facility is located adjacent to the northern boundary of Lorena Cemetery and immediately west of the Missouri-Kansas-Texas Railroad right-of-way, approximately 3,500 feet south of the intersection of Center Street and Front Street in McLennan County, Texas.

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, Toll Free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-200900262
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: January 21, 2009

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Texas Facilities Commission

Request for Proposals #303-9-10833

The Texas Facilities Commission (TFC), on behalf of the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS), announces the issuance of Request for Proposals (RFP) #303-9-10833. TFC seeks a ten (10) year lease of approximately 5,507 square feet of office space in Northwest Henderson County, Texas.

The deadline for questions is February 6, 2009 and the deadline for proposals is February 13, 2009 at 3:00 p.m. The award date is March 18, 2009. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TFC Purchaser Sandy Williams at (512) 475-0453. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=80651*.

TRD-200900266
Kay Molina
General Counsel
Texas Facilities Commission
Filed: January 21, 2009

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Office of the Governor

Notice of Application and Priorities for the Justice Assistance Grant Program Federal Application

The Governor's Criminal Justice Division (CJD) is preparing its application for the 2009 federal Edward Byrne Justice Assistance Grant Program (JAG). The amount available for this program will be determined after congressional adoption of the federal Fiscal Year 2009 (FFY) appropriation for the U.S. Department of Justice.

CJD received supplemental JAG funds totaling $741,487 in federal Fiscal Year 2008. CJD proposes to use its FFY 2008 supplemental funds and FFY 2009 funds for projects that reduce violent crime.

Comments on the application or the priorities may be submitted in writing to Judy Switzer by email at jswitzer@governor.state.tx.us or mailed to the Criminal Justice Division, Office of the Governor, P.O. Box 12428, Austin, Texas 78711. Comments must be received or postmarked no later than 30 days from the date of publication of this announcement in the *Texas Register.*

TRD-200900267
Kevin Green
Assistant General Counsel
Office of the Governor
Filed: January 21, 2009

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Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission announces its intent to submit an amendment to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment is effective February 1, 2009.

The amendment will modify the reimbursement methodology in the Texas Medicaid State Plan for ambulance services by allowing cost-based reimbursement to Austin-Travis County Emergency Medical Services, a governmental third-party ambulance service provider. The provider will be subject to annual cost-reporting requirements, cost reconciliation, and cost settlement.

The proposed amendment is estimated to result in an additional annual aggregate expenditure of $708,270 for federal fiscal year (FFY) 2009, with approximately $420,996 in federal funds and $287,274 in State General Revenue (GR). For FFY 2010, the estimated additional aggregate expenditure is $1,013,109, with approximately $594,999 in federal funds and $418,110 in GR. For FFY 2011, the estimated additional aggregate expenditure is $1,087,471, with approximately $633,343 in federal funds and $454,128 in GR.

Interested parties may obtain copies of the proposed amendment by contacting Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1432; by facsimile at (512) 491-1998; or by e-mail at Dan.Huggins@hhsc.state.tx.us. Copies of

the proposals will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-200900221
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: January 20, 2009

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Public Notice

The Texas Health and Human Services Commission (HHSC) intends to submit to the Centers for Medicare and Medicaid Services a request to renew the Texas Disease Management (DM) program. The DM program is a Medicaid waiver program under the authority of Title XIX, §1915(b) of the Social Security Act. The proposed effective date for the renewal is August 1, 2009.

The waiver renewal provides for the continuation of the disease management program, which HHSC developed pursuant to the requirements of H.B. 727, 78th Legislature, Regular Session, 2003. The disease management program is in addition to current Medicaid services provided to Primary Care Case Management and fee-for-service clients.

The program is designed to be an educational and care management service for individuals who receive services through the Texas Medicaid Program and who have one or more of the following conditions: Congestive Heart Failure, Asthma, Diabetes, Chronic Obstructive Pulmonary Disease and Coronary Artery Disease.

HHSC is requesting that the waiver renewal be approved for an additional two year period beginning August 1, 2009 through July 31, 2011. This waiver maintains cost neutrality for waiver years 2009 through 2011.

To obtain copies of the proposed waiver, interested parties may contact Christine Longoria by mail at Texas Health and Human Services Commission, P.O. Box 85200, mail code H-600, Austin, Texas 78708-5200, phone (512) 491-1152, fax (512) 491-1953, or by e-mail at christine.longoria@hhsc.state.tx.us.

TRD-200900224
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: January 20, 2009

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Department of State Health Services

Notice of Certification of Nonprofit Hospitals or Hospital Systems for Limited Liability

The Hospital Survey Unit in the Center for Health Statistics, Department of State Health Services (department), has completed its analysis of hospital data for the purpose of certifying nonprofit hospitals or hospital systems for limited liability in accordance with the Health and Safety Code, §311.0456. We received requests for certification from 6 hospitals. We will notify each hospital by mail that is certified and non-certified in accordance with §311.0456. If you have any comments or questions about the following certification results, please contact Mr. Dwayne Collins or Ms. JaNell Jenkins of the department's Center for Health Statistics.

Certified. 2 non-profit hospitals were determined to be eligible for certification based on information (2007 annual survey of hospitals and/or the 2007 annual statement of community benefits) that they provided 8 percent or more of their net patient revenue as charity care and provided 40 percent or more of the charity care in their counties:

1. Shannon West Texas Memorial Hospital in Tom Green County;

2. University Medical Center at Brackenridge Hospital in Travis County.

Not Certified. 4 non-profit hospitals were not certified based on information (2007 annual survey of hospitals and 2007 annual statement of community benefits) that they did not provide 8 percent of their net patient revenue as charity care nor did they provide 40 percent of the charity care in their counties:

1. Memorial Medical Center of East Texas in Angelina County;

2. Memorial Specialty Hospital in Angelina County;

3. Memorial Medical Center - Livingston in Polk County;

4. Memorial Medical Center - San Augustine in San Augustine County.

For further information about this report, please contact Mr. Dwayne Collins or Ms. JaNell Jenkins in the Center for Health Statistics, Department of State Health Services, 1100 West 49th Street, Austin, Texas, telephone (512) 458-7261.

TRD-200900216
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: January 16, 2009

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Texas Lottery Commission

Instant Game Number 1101 "$140,000,000 Extreme Payout"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1101 is "$140,000,000 EXTREME PAYOUT". The play style is "key number match with multipliers".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1101 shall be $50.00 per ticket.

1.2 Definitions in Instant Game No. 1101.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 2X SYMBOL, 10X SYMBOL, $50.00, $70.00, $75.00, $100, $250, $500, $1,000, $2,000, and $10 MILL.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1101 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
21	TWON
22	TWTO
23	TWTH
24	TWFR
25	TWFV
26	TWSX
27	TWSV
28	TWET
29	TWNI
30	TRTY
31	TRON
32	TRTO
33	TRTH
34	TRFR
35	TRFV
36	TRSX
37	TRSV
38	TRET
39	TRNI
40	FRTY
2X SYMBOL	WINX2
10X SYMBOL	WINX10
$50.00	FIFTY
$70.00	SEVENTY
$75.00	SVY FIV
$100	ONE HUND
$250	TWO FTY
$500	FIV HUND

$1,000	ONE THOU
$2,000	TWO THOU
$10 MILL	TEN MILL

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Mid-Tier Prize - A prize of $50.00, $70.00, $75.00, $100, $140, $150, $200, $240, $250, $350 or $500.

H. High-Tier Prize - A prize of $1,000, $2,000, $10,000 or $10,000,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1101), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 020 within each pack. The format will be: 1101-0000001-001.

K. Pack - A pack of "$140,000,000 EXTREME PAYOUT" Instant Game tickets contains 020 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). Ticket back 001 and 020 will both be exposed.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "$140,000,000 EXTREME PAYOUT" Instant Game No. 1101 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "$140,000,000 EXTREME PAYOUT" Instant Game is determined once the latex on the ticket is scratched off to expose 65 (sixty-five) Play Symbols. If a player matches any of YOUR NUMBERS play symbols to any of the WINNING NUMBERS play symbols, the player wins the PRIZE shown for that number. If a player reveals a "2X" play symbol, the player wins DOUBLE the PRIZE shown for that symbol. If a player reveals a "10X" play symbol, the player wins 10 TIMES the PRIZE shown for that symbol. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 65 (sixty-five) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 65 (sixty-five) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 65 (sixty-five) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 65 (sixty-five) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award

of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets in a pack will not have identical play data, spot for spot.

B. No duplicate non-winning YOUR NUMBERS play symbols on a ticket.

C. No duplicate WINNING NUMBERS play symbols on a ticket.

D. No five or more matching non-winning prize symbols on a ticket.

E. The $10,000,000 prize symbol will appear on every ticket unless otherwise restricted.

F. Non-winning prize symbols will not match winning prize symbols on a ticket.

G. The "2X" (doubler) and "10X" (win x 10) play symbols will only appear on winning tickets as dictated by the prize structure.

H. When breaking the YOUR NUMBERS and WINNING NUMBERS symbols into the individual digits that make up the symbols, there will never be an occurrence of a non-winning YOUR NUMBER play symbol's digit equaling a WINNING NUMBER play symbol's digit with the non-winning YOUR NUMBER play symbol's corresponding prize symbol is equal to the highest valued prize in the game.

2.3 Procedure for Claiming Prizes.

A. To claim a "$140,000,000 EXTREME PAYOUT" Instant Game prize of $50.00, $70.00, $75.00, $100, $140, $150, $200, $240, $250, $350 or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required to pay a $50.00, $70.00, $75.00, $100, $140, $150, $200, $240, $250, $350 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "$140,000,000 EXTREME PAYOUT" Instant Game prize of $1,000, $2,000, $10,000 or $10,000,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. To claim a "$140,000,000 EXTREME PAYOUT" top level prize of $10,000,000, the claimant must sign the winning ticket and present it at Texas Lottery Commission headquarters in Austin, Texas. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. As an alternative method of claiming a "$140,000,000 EXTREME PAYOUT" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

E. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

F. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "$140,000,000 EXTREME PAYOUT" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "$140,000,000 EXTREME PAYOUT" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 3,600,000 tickets in the Instant Game No. 1101. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1101 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$50	540,000	6.67
$70	540,000	6.67
$75	90,000	40.00
$100	120,600	29.85
$140	20,250	177.78
$150	20,040	179.64
$200	15,000	240.00
$240	6,300	571.43
$250	6,000	600.00
$350	6,000	600.00
$500	9,000	400.00
$1,000	4,200	857.14
$2,000	1,500	2,400.00
$10,000	100	36,000.00
$10,000,000	3	1,200,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 2.61. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1101 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1101, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200900218

Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: January 20, 2009

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Instant Game Number 1175 "In the Money"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1175 is "IN THE MONEY". The play style is "key number match with win all".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1175 shall be $2.00 per ticket.

1.2 Definitions in Instant Game No. 1175.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, MONEYBAG SYMBOL, $2.00, $4.00, $5.00, $10.00, $20.00, $25.00, $50.00, $100, $500, $2,000 and $20,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1175 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
17	SVT
18	ETN
19	NTN
20	TWY
MONEYBAG SYMBOL	WIN
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$25.00	TWY FIV
$50.00	FIFTY
$100	ONE HUND
$500	FIV HUND
$2,000	TWO THOU
$20,000	20 THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $2.00, $4.00, $5.00, $10.00 or $20.00.

G. Mid-Tier Prize - A prize of $50.00, $100 or $500.

H. High-Tier Prize- A prize of $2,000 or $20,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1175), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 125 within each pack. The format will be: 1175-0000001-001.

K. Pack - A pack of "IN THE MONEY" Instant Game tickets contains 125 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). There will be 2 fanfold configurations for this game. Configuration A will show the front of ticket 001 and the back of ticket

125. Configuration B will show the back of ticket 001 and the front of ticket 125.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "IN THE MONEY" Instant Game No. 1175 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "IN THE MONEY" Instant Game is determined once the latex on the ticket is scratched off to expose 22 (twenty-two) Play Symbols. If a player matches any of YOUR NUMBERS play symbols to either WINNING NUMBER play symbol, the player wins the PRIZE shown for that number. If a player reveals a "moneybag" play symbol, the player wins ALL 10 PRIZES shown instantly! No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 22 (twenty-two) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 22 (twenty-two) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 22 (twenty-two) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 22 (twenty-two) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets in a pack will not have identical play data, spot for spot.

B. The "MONEY BAG" (win all) play symbol will only appear on intended winning tickets and only as dictated by the prize structure.

C. When the "MONEY BAG" (win all) play symbol appears, there will no occurrence of any YOUR NUMBERS play symbols matching to either WINNING NUMBER play symbol.

D. No more than two (2) matching non-winning prize symbols will appear on a ticket.

E. No duplicate WINNING NUMBERS play symbols on a ticket.

F. No duplicate non-winning YOUR NUMBERS play symbols on a ticket.

G. Non-winning prize symbols will never be the same as the winning prize symbol(s).

H. No prize amount in a non-winning spot will correspond with the YOUR NUMBERS play symbol (i.e. 5 and $5).

I. The top prize symbol will appear on every ticket unless otherwise restricted.

2.3 Procedure for Claiming Prizes.

A. To claim a "IN THE MONEY" Instant Game prize of $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present

the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required to pay a $50.00, $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "IN THE MONEY" Instant Game prize of $2,000 or $20,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "IN THE MONEY" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "IN THE MONEY" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "IN THE MONEY" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 7,080,000 tickets in the Instant Game No. 1175. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1175 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	509,760	13.89
$4	679,680	10.42
$5	84,960	83.33
$10	99,120	71.43
$20	42,480	166.67
$50	27,671	255.86
$100	11,800	600.00
$500	826	8,571.43
$2,000	21	337,142.86
$20,000	9	786,666.67

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.86. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1175 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1175, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200900219
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: January 20, 2009

♦ ♦ ♦

Instant Game Number 1177 "Monopoly™"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1177 is "MONOPOLY™". The play style is "key symbol match with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1177 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 1177.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the instant ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: WATER SYMBOL, HAT SYMBOL, IRON SYMBOL, SHOE SYMBOL, DOG SYMBOL, BULB SYMBOL, THIMBLE SYMBOL, WHEEL BARREL SYMBOL, TRAIN SYMBOL, CAR SYMBOL, $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, $100, and $1,000.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1177 - 1.2D

PLAY SYMBOL	CAPTION
WATER SYMBOL	WATER
HAT SYMBOL	HAT
IRON SYMBOL	IRON
SHOE SYMBOL	SHOE
DOG SYMBOL	DOG
BULB SYMBOL	BULB
THIMBLE SYMBOL	TMBLE
WHEEL BARREL SYMBOL	WHBRW
TRAIN SYMBOL	TRAIN
CAR SYMBOL	CAR
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$40.00	FORTY
$100	ONE HUND
$1,000	ONE THOU

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There will be a four (4)-digit "security number" which will be individually boxed and randomly placed within the number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $1.00, $2.00, $4.00, $5.00, $10.00, or $20.00

G. Mid-Tier Prize - A prize of $40.00 or $100.

H. High-Tier Prize - A prize of $1,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number, and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1177), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 150 within each pack. The format will be: 1177-0000001-001.

K. Pack - A pack of "MONOPOLY™" Instant Game tickets contains 150 tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). One ticket will be folded over to expose a front and back of one ticket on each pack. Please note the books will be in an A, B. C, and D configuration.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "MONOPOLY™" Instant Game No. 1177 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "MONOPOLY™" Instant Game is determined once the latex on the ticket is scratched off to expose 11 (eleven) Play Symbols. If a player matches any of YOUR SYMBOLS play symbols to the WINNING SYMBOL play symbol, the player wins the PRIZE shown for that symbol. If the player reveals a "car" play symbol, the player wins the PRIZE shown for that symbol instantly. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 11 (eleven) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted, or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 11 (eleven) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective, or printed or produced in error;

16. Each of the 11 (eleven) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 11 (eleven) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets in a pack will not have identical play data, spot for spot.

B. No duplicate non-winning prize symbols on a ticket.

C. No duplicate non-winning YOUR SYMBOLS play symbols on a ticket.

D. Non-winning prize symbols will never be the same as the winning prize symbol(s).

E. The "CAR" (auto win) play symbol will never appear more than once on a ticket.

F. The top prize will appear on every ticket unless otherwise restricted by the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "MONOPOLY™" Instant Game prize of $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $40.00, or $100, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required to pay a $40.00 or $100 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and Section 2.3.C of these Game Procedures.

B. To claim a "MONOPOLY™" Instant Game prize of $1,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "MONOPOLY™" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller of Public Accounts, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Office of the Attorney General;

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resources Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "MONOPOLY™" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "MONOPOLY™" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales, and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 10,080,000 tickets in the Instant Game No. 1177. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1177 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$1	1,008,000	10.00
$2	604,800	16.67
$4	268,800	37.50
$5	67,200	150.00
$10	67,200	150.00
$20	33,600	300.00
$40	15,750	640.00
$100	1,176	8,571.43
$1,000	126	80,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.88. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery Commission.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1177

without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1177, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-200900220
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: January 20, 2009

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Panhandle Regional Planning Commission

Legal Notice

The Panhandle Regional Planning Commission (PRPC) seeks a vendor or vendors that can supply pre-paid fuel cards usable for the purchase of fuel by workforce development program customers at outlets in the Panhandle Workforce Development Area (PWDA).

Cards must be available pre-loaded in various denominations directly from the vendor and limited to fuel purchases only.

PRPC makes no guarantees of purchases from the selected vendor(s) and reserves the right to use alternative methods to purchase fuel.

Interested vendors may obtain a copy of the solicitation packet by contacting Tony White, at (806) 372-3381/(800) 477-4562 or twhite@theprpc.org. The packet may also be picked up at PRPC's offices located at 415 West Eighth in Amarillo, Texas. The required information should be submitted to PRPC no later than February 11, 2009.

TRD-200900239
Anthony White
Workforce Development Assistant Director
Panhandle Regional Planning Commission
Filed: January 21, 2009

♦ ♦ ♦

Texas Parks and Wildlife Department

Notice of Availability and Request for Public Comment

Draft Damage Assessment and Restoration Plan

AGENCIES: Texas Parks and Wildlife Department (TPWD), Texas Commission on Environmental Quality (TCEQ), Texas General Land Office (GLO), and the United States Department of the Interior represented by the United States Fish and Wildlife Service (USFWS) (collectively, the Trustees).

ACTION: Notice of availability of a Draft Damage Assessment and Restoration Plan (DARP) for natural resource damages resulting from the impacts of the July 14, 2007 Explorer Pipeline Jet A fuel discharge into and adjacent to Turkey Creek in Walker County, Texas and of a 30-day period for public comment on the Draft DARP beginning the date of publication of this notice.

SUMMARY: This notice serves to inform the public that the Natural Resource Trustees have developed a Draft DARP to resolve Natural Resource Damages associated with this incident. The Draft DARP outlines the injuries resulting from the unauthorized discharge of Jet A fuel into Turkey Creek and the adjacent habitats, as well as the proposed restoration project selected to compensate for those injuries.

The opportunity for public review and comment on the Draft DARP announced in this notice is required under the Oil Pollution Act (OPA) 33 U.S.C. §2706(c)(5), and parallels provisions of 15 CFR §990.14(d) and §990.55 of the federal Natural Resource Damage Assessment regulations.

ADDRESSES: A copy of this Draft DARP may be obtained by contacting: Johanna Gregory, Natural Resource Trustee, Environmental Assessment and Restoration Program, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744, Phone: (512) 389-8703, e-mail: johanna.gregory@tpwd.state.tx.us.

DATES: Comments must be submitted in writing within 30 days of the publication of this notice to Johanna Gregory of the Texas Parks and Wildlife Department at the address listed in the previous paragraph. The Natural Resource Trustees will consider written comments received during the 30-day comment period prior to finalizing the Draft DARP.

SUPPLEMENTARY INFORMATION: On July 14, 2007, a 5-foot split occurred in a 28-inch, high-pressure transmission line belonging to Explorer Pipeline, resulting in an unauthorized discharge of Jet A fuel just east of the City of Huntsville, in Walker County, Texas (Incident). Approximately 6,568 barrels (275,860 gallons) of jet fuel were discharged onto land and into Turkey Creek and adjacent riparian habitat. Jet fuel was observed at the discharge point and extended about 4.5 miles downstream within Turkey Creek. Fish and wildlife kills, tree mortality, and impacts to terrestrial habitat were observed at the spill site.

Initial response activities included building earthen berms within Turkey Creek, excavating the pipeline, and recovering free product from Turkey Creek with vacuum trucks. Response actions included the use of heavy equipment to excavate and remove the damaged section of line, as well as provide access to Turkey Creek. During secondary response activities, the responders washed the banks of Turkey Creek to remove residual Jet A fuel and consolidated the product into central areas to facilitate collection of the free product. Response actions removed a large portion of the Jet A fuel from Turkey Creek within 8 days of the release. Monitoring and maintenance activities continued through August 2008.

Natural resources or their services impacted as a result of the spill and spill response included riparian and upland wooded habitat, pasture habitat, and aquatic habitat of Turkey Creek. Biota impacted by the spill includes fish, birds, other wildlife species, and benthic communities.

Natural Resource Trustees have the authority under OPA (33 U.S.C. §2701 et seq.) to assess natural resource injuries resulting from this Incident. TCEQ, TPWD, GLO, and USFWS are Trustees of the natural resources injured by the Explorer Pipeline discharge.

The Natural Resource Trustees have determined that resources subject to their trust authority under this Act were exposed to Jet A fuel as a result of the discharge. The quantity and concentration of the material discharged was sufficient to result in the impairment of exposed habitats. Explorer Pipeline, as the designated responsible party, entered into a Memorandum of Agreement with the Trustees to perform a cooperative restoration-based assessment to address potential or actual natural resource injuries and lost services resulting from the spill. The Trustees and Explorer Pipeline jointly performed site investigations on August 20, 2007 and May 28, 2008, to assess lost natural resource services resulting from the discharge and the associated response actions. Results from site investigations and Habitat Equivalency Analysis were used to

determine the scale of restoration necessary to compensate for injuries to natural resource services.

In accordance with the OPA regulations, the Trustees evaluated a reasonable range of restoration alternatives to compensate for injuries to natural resources and associated lost services. After examining restoration alternatives and potential restoration sites, the Trustees have identified the acquisition and preservation of existing high quality habitat located along 3.28 miles of the Angelina Riverfront to be incorporated as part of the TPWD Alazan Bayou Wildlife Management Area as the preferred restoration alternative. The Trustees are seeking public input on a proposal to use Natural Resources Damages recovered for the spill as matching funds to preserve a 486-acre tract in Angelina County as compensation for injuries related to the spill.

For further information contact: Johanna Gregory at (512) 389-8703, fax: (512) 389-8160, e-mail: johanna.gregory@tpwd.state.tx.us.

TRD-200900243
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Filed: January 21, 2009

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Public Utility Commission of Texas

Announcement of Application for an Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on January 15, 2009, for an amendment to a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Comcast of Houston, LLC for an Amendment to its State-Issued Certificate of Franchise Authority, Project Number 36600 before the Public Utility Commission of Texas.

The requested amended CFA service area includes the area within the boundaries of the municipality of Richwood, Texas, including any future annexations.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 36600.

TRD-200900252
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 13, 2009, for retail electric provider (REP) certification, pursuant to Public Utility Regulatory Act (PURA) §§39.101 - 39.109.

Docket Title and Number: Application of Iluminar Energy, LLC for Retail Electric Provider (REP) Certification, Docket Number 36583 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the entire state of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36583.

TRD-200900222
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 20, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep5 for Retail Electric Provider (REP) Certification, Docket Number 36587 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36587.

TRD-200900255
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep6 for Retail Electric Provider (REP) Certification, Docket Number 36588 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36588.

TRD-200900256
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep7 for Retail Electric Provider (REP) Certification, Docket Number 36589 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36589.

TRD-200900257
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep8 for REP Certification, Docket Number 36590 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36590.

TRD-200900258
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep9 for REP Certification, Docket Number 36591 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36591.

TRD-200900259
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of TexRep10 for REP Certification, Docket Number 36592 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the Electric Reliability Council of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36592.

TRD-200900254
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on January 14, 2009, for retail electric provider (REP) certification, pursuant to §§39.101 - 39.109 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of Telecom Consulting and Services, LLC d/b/a TCS Energy for REP Certification, Docket Number 36593 before the Public Utility Commission of Texas.

Applicant's requested service area by geography includes the geographic area of the entire State of Texas.

Persons wishing to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than February 6, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 36593.

TRD-200900253
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 21, 2009

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How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 33 (2008) is cited
as follows: 33 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "33 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 33 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).